Exhibit 1

SUMMARY PLAN DESCRIPTION FOR:

Swire Pacific Holdings, Inc.

Group Number: 60021265

Medical Plan

Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Utah

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347（TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

Introduction

Welcome to participation in the self-funded group health plan (hereafter referred to as "Plan") provided for You by Your employer. Your employer has chosen Regence BlueCross BlueShield of Utah to administer claims for Your group health plan. Throughout this Summary Plan Description, Your employer may be referred to as the "Plan Sponsor."

EMPLOYER PAID BENEFITS

Your Plan is an employer-paid benefits plan administered by Regence BlueCross BlueShield of Utah (usually referred to as the "Claims Administrator" in this Summary Plan Description). This means that Your employer, not Regence BlueCross BlueShield of Utah, pays for Your covered medical services and supplies. Your claims will be paid only after Your employer provides Regence BlueCross BlueShield of Utah with the funds to pay Your benefits and pay all other charges due under the Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Because of their extensive experience and reputation of service, Regence BlueCross BlueShield of Utah has been chosen as the Claims Administrator of Your Plan.

The following pages are the Summary Plan Description, the written description of the terms and benefits of coverage available under the Plan. This Summary Plan Description describes benefits effective **January 1, 2018**, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any plan description, Summary Plan Description or certificate previously issued by Regence BlueCross BlueShield of Utah and makes it void.

As You read this Summary Plan Description, please keep in mind that references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Who Is Eligible, How To Enroll and When Coverage Begins, When Coverage Ends and COBRA Continuation sections, the terms "You" and "Your" mean the Participant only). (NOTE: Where a reference is made to spouse, all of the same terms and conditions of the Summary Plan Description will be applied to a domestic partner, except when specified to the contrary.) The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used and are designated by the first letter being capitalized.

This employee benefit plan may be governed by the Employee Retirement Income Security Act (ERISA). Throughout the Summary Plan Description, references to "ERISA" will apply only if the Plan is part of an employee welfare benefit plan regulated under ERISA.

Federal law mandates coverage for certain breast reconstruction services in connection with a covered mastectomy. See Women's Health and Cancer Rights in the General Provisions Section in this Summary Plan Description for details.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act: Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (for example, Your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain preauthorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain preauthorization. For information on preauthorization, contact Your Plan Administrator.

Notice of Privacy Practices: Regence BlueCross BlueShield of Utah has a Notice of Privacy Practices that is available by calling Customer Service or visiting the Web site listed below.

CONTACT INFORMATION

If You have questions, would like to learn more about Your coverage, would like to request written or electronic information or to talk with one of the Claims Administrator's Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. – 6 p.m. Pacific Time.

Customer Service: 1 (866) 240-9580
(TTY: 711)

Or visit the Claims Administrator's Web site at: **regence.com**

For assistance in a language other than English please call the Customer Service telephone number.

Case Management. You can request that a case manager be assigned or You may be assigned a case manager to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. Call Case Management at 1 (866) 543-5765.

BlueCard® Program. Learn how to have access to care through the BlueCard Program. This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.

Using Your Summary Plan Description

YOUR PARTNER IN HEALTH CARE

This Plan, administered by Regence, provides You with great benefits that are quickly accessible and easy to understand, thanks to open access to Providers and innovative tools. With this health care coverage, You will discover the personal freedom to make informed health care decisions, as well as the assistance You need to navigate the health care system.

YOU SELECT YOUR PROVIDER AND CONTROL YOUR OUT-OF-POCKET EXPENSES

Your Plan allows You to control Your out-of-pocket expenses, such as Copayments and Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your Provider under two choices called: "In-Network" and "Out-of-Network."

- **In-Network.** You choose to see an In-Network Provider and save the most in Your out-of-pocket expenses. Choosing this Provider option means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network.** You choose to see an Out-of-Network Provider that does not have a participating contract with the Claims Administrator and Your out-of-pocket expenses will generally be higher than seeing an In-Network Provider. Also, choosing this Provider option means You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. This is sometimes referred to as balance billing.

For each benefit in this Summary Plan Description, the Provider You may choose and Your payment amount for each Provider option is indicated. In-Network and Out-of-Network are also in the Definitions Section in this Summary Plan Description. You can go to **regence.com** for further Provider network information.

ADDITIONAL PARTICIPATION ADVANTAGES

Your Plan offers You access to valuable services. The advantages of Regence involvement as the Claims Administrator include access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to **regence.com**, an interactive environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.**

- **Go to regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have Your Plan identification card handy to log on. Use the secure Web site to:

  - view recent claims, benefits and coverage;
  - find a contracting Provider;
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs;
  - discover discounts on select items and services*;
  - identify Participating Pharmacies;
  - find alternatives to expensive medicines;
  - learn about prescriptions for various Illnesses; and
  - compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this Plan, that also may create savings for the Claims Administrator. Any such discounts or coupons are complements to the group health plan, but are not insurance.

ENHANCED SERVICES, SUPPORT, AND ACCESS

Your Plan has chosen to include enhanced services, support, and access. These enhancements will allow You to take increased advantage of Your health plan and better control over Your and Your family's health. Such services may include, but are not limited to:

- **Enhanced convenience and options for access to medical care.** These may include additional resources for You to receive covered medical care, such as enhanced virtual care options that are integrated with Your telemedicine, durable medical equipment, preventive, behavioral health, and/or other benefits. You may also be offered increased ease in accessing non-Covered Services, such as cosmetic services or in integrating care for complex and multi-Provider conditions.
- **Healthcare and vitality assistance tools.** You may have tools that enable You to make and track medical appointments; manage health care expenses; receive support in caring for others; remember to timely refill prescriptions and perform regular self-care; track weight, food, and exercise statistics; receive coaching; and more.
- **Non-medical lifestyle enhancements.** These may include access or assistance with non-medical services, such as resilience, mindfulness, yoga or stress reduction programs, and pet wellness and insurances services.

Your Plan's enhancements can be accessed through a single-sign on by visiting the Claims Administrator's Web site, or by contacting Customer Service. These services are specialized and may change over time. Your use of these additional services selected by Your Plan Sponsor is voluntary. In some cases, the Claims Administrator may have an affiliation with the entity that performs the services purchased by Your Plan Sponsor. The use of these services may result in savings or value to You, Your employer, and the Claims Administrator. **ANY SUCH ENHANCED SERVICES, SUPPORT, AND ACCESS ARE COMPLEMENTS TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.**

Table of Contents

Understanding Your Benefits

In this section, You will discover information to help You understand what is meant by Your Maximum Benefits, Deductibles (if any), Copayments, Coinsurance and Out-of-Pocket Maximum. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used and are designated by the first letter being capitalized.

While this Understanding Your Benefits Section defines these types of cost-sharing elements, You need to refer to the Medical Benefits Section to see exactly how they are applied and to which benefits they apply.

MAXIMUM BENEFITS

Some benefits for Covered Services may have a specific Maximum Benefit. For those Covered Services, benefits will be provided until the specified Maximum Benefit (which may be a number of days, visits, services, supplies, dollar amount or specified time period) has been reached. Allowed Amounts for Covered Services provided are also applied toward the Deductible and against any specific Maximum Benefit that is expressed in this Summary Plan Description. Refer to the Medical Benefits Section in this Summary Plan Description to determine if a Covered Service has a specific Maximum Benefit.

OUT-OF-POCKET MAXIMUM

Claimants can meet the Out-of-Pocket Maximum by payments of Deductible, Copayments and/or Coinsurance as specifically indicated in the Medical Benefits and Prescription Medication Benefits Sections. There are two Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. The Medical Benefits Section describes this more fully, but in this Summary Plan Description, the term is referred to simply as "the Out-of-Pocket Maximum." A Claimant's payment of any Deductible, Copayment and Coinsurance for Detoxification, emergency room services, Prescription Medication Benefits and benefits listed in the Medical Benefits Section that show under the Provider "All" will apply toward the In-Network Out-of-Pocket Maximum amount. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach this Plan's Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year.

There are two Family Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. The Family Out-of-Pocket Maximum for a Calendar Year is satisfied when three or more Family members' Deductibles, Copayments and/or Coinsurance for Covered Services for that Calendar Year total and meet the Family Out-of-Pocket Maximum amount. One Claimant may not contribute more than the individual Out-of-Pocket Maximum amount.

COPAYMENTS

Copayments are the fixed dollar amount that You must pay directly to the Provider for certain office visit benefits, emergency room visits or Prescription Medications each time You receive a specified service or medication (as applicable). The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service or medication. Refer to the Medical Benefits Section to understand what Copayments You are responsible for.

Copayments applicable to Prescription Medications are located in the Prescription Medication Benefits Section in this Summary Plan Description.

PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)

Once You have satisfied any applicable Deductible and any applicable Copayment, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount. The percentage the Plan pays varies, depending on the kind of service or supply You received and who rendered it.

The Plan does not reimburse Providers for charges above the Allowed Amount. An In-Network Provider will not charge You for any balances for Covered Services beyond Your Deductible, Copayment and/or Coinsurance amount. Out-of-Network Providers, however, may bill You for any balances over the Plan payment level in addition to any Deductible, Copayment and/or Coinsurance amount. See the Definitions Section for descriptions of Providers.

Coinsurance amounts applicable to Prescription Medications are located in the Prescription Medication Benefits Section in this Summary Plan Description.

DEDUCTIBLES

The Plan will begin to pay benefits for Covered Services in any Calendar Year only after a Claimant satisfies the Calendar Year Deductible. A Claimant satisfies the Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible.

The Family Calendar Year Deductible is satisfied when three or more covered Family members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. One Claimant may not contribute more than the individual Deductible amount.

The Plan does not pay for services applied toward the Deductible. Refer to the Medical Benefits Section to see if a particular service is subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not count toward the Deductible.

HOW CALENDAR YEAR BENEFITS RENEW

Many provisions in this Plan (for example, Deductibles, Out-of-Pocket Maximum and certain benefit maximums) are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again.

Some benefits in this Plan have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Calendar Year. Those exceptions are specifically noted in the benefits sections in this Summary Plan Description.

Medical Benefits

In this section, You will learn about Your health plan's benefits and how Your coverage pays for Covered Services. There are no referrals required before You can use any of the benefits of this coverage, including women's health care services. For Your ease in finding the information regarding benefits most important to You, these benefits have been listed alphabetically, with the exception of the Upfront, Preventive Care and Immunizations and Other Professional Services benefits.

All covered benefits are subject to the limitations, exclusions and provisions of this Plan. In some cases, the Plan may limit benefits or coverage to a less costly and Medically Necessary alternative item. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the Definitions Section in the back of this Summary Plan Description for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

Reimbursement may be available under the Plan for some medical supplies, equipment and devices You purchase from a Provider or from an approved Commercial Seller, even though that seller is not a Provider. Medical supplies, equipment and devices, such as a breast pump or wheelchair, purchased through an approved Commercial Seller are covered at the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. To learn more about how to access reimbursable retail medical supplies, equipment and devices, please visit the Claims Administrator's Web site or contact Customer Service.

NOTE: If You choose to access medical supplies, equipment and devices through the Claims Administrator's Web site, the Plan may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are a complement to the group health plan, but are not insurance.

A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service under the Plan.

If benefits under the Plan change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

In-Network
Per Claimant: $2,200
Per Family: $6,600

Out-of-Network
Per Claimant: $3,700
Per Family: $11,100

COPAYMENTS AND COINSURANCE

Copayments and Coinsurance are listed in the tables for Covered Services for each applicable benefit.

CALENDAR YEAR DEDUCTIBLES

Per Claimant: $300
Per Family: $900

You do not need to meet any Deductible before receiving benefits for:

- Preventive Care and Immunizations; and
- emergency room services.

PREVENTIVE CARE AND IMMUNIZATIONS

Benefits will be covered under this Preventive Care and Immunizations benefit, not any other provision in this Summary Plan Description, if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this benefit, including information about obtaining a breast pump from an approved Commercial Seller, please visit the Claims Administrator's Web site or contact Customer Service. NOTE: Covered Services that do not meet these criteria will be covered the same as any other Illness or Injury.

Preventive Care

Provider: In-Network	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.

The Plan covers preventive care services provided by a professional Provider or facility. Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings. Also included is Provider counseling for tobacco use cessation and medications prescribed for tobacco use cessation. See the Prescription Medication Benefits Section in this Summary Plan Description for a description of how tobacco use cessation medications are covered. Coverage for all such services is provided only for preventive care as designated above (which designation may be modified from time to time).

The Plan covers one non-Hospital grade breast pump (including its accompanying supplies) per pregnancy at the In-Network benefit level when obtained from a Provider (including a Durable Medical Equipment supplier). Alternatively, a comparable breast pump may be obtained from an approved Commercial Seller in lieu of a Provider. Benefits for a comparable breast pump obtained from an approved Commercial Seller will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit the Claims Administrator's Web site or contact Customer Service.

Additionally, the Plan covers all United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women in accordance with HRSA recommendations. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill, and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products), intrauterine devices (both copper and those with progestin), implantable contraceptive rod, surgical implants and surgical sterilization. Please visit the Claims Administrator's Web site for the preferred contraceptive products covered under the Prescription Medication Benefit.

Immunizations – Adult

Provider: In-Network	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.

The Plan covers immunizations for adults according to, and as recommended by, the USPSTF and the CDC. Covered expenses do not include immunizations if the Claimant receives them only for purposes of travel, occupation or residence in a foreign country.

Immunizations – Childhood

Provider: In-Network	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.

The Plan covers immunizations for children (up to 18 years of age) according to, and as recommended by, the USPSTF and the CDC.

BENEFITS COVERED AFTER DEDUCTIBLE

For Your ease in finding the information regarding benefits most important to You, the Plan has listed these benefits alphabetically, with the exception of the Preventive Care and Immunizations and Other Professional Services benefits.

OTHER PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Unless otherwise covered under Upfront Benefits or Preventive Care, the Plan covers services and supplies provided by a professional Provider subject to any Deductible and/or Coinsurance and any specified limits as explained in the following paragraphs:

Medical Services and Supplies

The Plan covers professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider, that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury. Services and supplies also include those to treat a congenital anomaly for Claimants up to age 26 and foot care associated with diabetes.

Additionally, the Plan covers certain Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are obtained from an approved Commercial Seller. Benefits for eligible supplies will be covered up the preferred benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit the Claims Administrator's Web site or contact Customer Service.

Office Visits

The Plan covers office visits for treatment of Illness or Injury.

Professional Inpatient

The Plan covers professional inpatient visits for Illness or Injury. If pre-arranged procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by an Out-of-Network Provider at the In-Network benefit level. However, You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact the Claims Administrator's Customer Service for further information and guidance.

Radiology and Laboratory

The Plan covers diagnostic services for treatment of Illness or Injury. This includes, but is not limited to, mammography services not covered under the Preventive Care and Immunizations benefit.

Diagnostic Procedures
The Plan covers services for diagnostic procedures including cardiovascular testing, colonoscopies, pulmonary function studies, sleep studies, stress tests and neurology/neuromuscular procedures.

Surgical Services
The Plan covers surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist.

Therapeutic Injections
The Plan covers therapeutic injections and related supplies when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered under the Prescription Medication Benefits Section in this Summary Plan Description. Teaching doses (by which a Provider educates the Claimant to self-inject) are covered for this list of Self-Administrable Medications up to a limit of three doses per medication per Claimant Lifetime. Teaching doses that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

AMBULANCE SERVICES

Provider: All
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers ambulance services to the nearest Hospital equipped to provide treatment, when any other form of transportation would endanger Your health and the purpose of the transportation is not for personal or convenience purposes. Covered ambulance services include licensed ground and air ambulance Providers.

AMBULATORY SURGICAL CENTER

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers outpatient services and supplies of an Ambulatory Surgical Center for Injury and Illness (including services of staff Providers).

APPROVED CLINICAL TRIALS
The Plan covers Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating subject to any Deductible, Coinsurance and/or Copayments and Maximum Benefits as specified in the Medical Benefits and Prescription Medication Benefits in this Summary Plan Description. Additional specified limits are as further defined. If a Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, these benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If the Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care.

Definitions
In addition to the definitions in the Definitions Section, the following definitions apply to this Approved Clinical Trials benefit:

Approved Clinical Trial means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to prevention, detection or treatment of cancer or other Life-threatening Condition and that is a study or investigation:

- Approved or funded by one or more of:

- The National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid or a cooperative group or center of any of those entities or of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
- A qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
- The VA, DOD or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review; or

- Conducted under an investigational new drug application reviewed by the Food and Drug Administration or that is a drug trial exempt from having an investigational new drug application.

Life-threatening Condition means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Routine Patient Costs means items and services that typically are Covered Services for a Claimant not enrolled in a clinical trial, but do not include:

- An Investigational item, device or service that is the subject of the Approved Clinical Trial;
- Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Claimant; or
- A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

AUTISM SPECTRUM DISORDER SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services for Autism Spectrum Disorder such as diagnosis (including assessments, evaluations or tests) and treatment (including Applied Behavioral Analysis, Behavioral Health, Pharmacy Care, psychiatric care, psychological care, or Therapeutic Care, and related equipment).

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Autism Spectrum Disorder Services benefit:

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder means pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Behavioral Health means counseling and treatment programs, including Applied Behavior Analysis, that are: necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and provided or supervised by a: board certified behavior analyst; or a person licensed under state law, whose scope of practice includes mental health services.

Pharmacy Care means health-related services to determine the need or effectiveness of Prescription Medications. For coverage of Prescription Medications, refer to the Prescription Medication Benefits Section in this Summary Plan Description.

Therapeutic Care means services provided by duly licensed or certified speech therapists, occupational therapists, or physical therapists.

BARIATRIC SERVICES

Bariatric Office Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Bariatric Surgery

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers bariatric surgery to treat obesity. Before You proceed with bariatric surgery, the Claims Administrator must evaluate and approve the surgery as meeting its published medical policy.

In addition to the exclusions listed in the General Exclusions Section, the Plan will not cover complications, revisions and reversals of bariatric surgery, unless the previous bariatric surgery was approved by the Claims Administrator.

BLOOD BANK

Provider: All
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers the services and supplies of a blood bank, excluding storage costs.

CLOTTING FACTOR PRODUCTS – OUTPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers plasma-derived and recombinant clotting factor products used in outpatient replacement therapy for hemophilia, Von Willebrand disease, and similar clotting disorders when received from a home infusion Provider. This benefit does not cover these products when provided by a Pharmacy.

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an Ambulatory Surgical Center or Hospital is necessary to safeguard Your health.

DETOXIFICATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 80% of the Allowed Amount and You pay balance of billed charges. Your 20% payment of the Allowed Amount will be applied toward the In-Network Out-of-Pocket Maximum.

The Plan covers Medically Necessary detoxification.

DIABETES SUPPLIES AND EQUIPMENT

The Plan covers supplies and equipment for the treatment of diabetes. Please refer to the Other Professional Services, Diabetic Education, Durable Medical Equipment, Nutritional Counseling, Orthotic Devices or Prescription Medication Benefits in this Summary Plan Description for coverage details of such covered supplies and equipment.

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services and supplies for diabetic self-management training and education, when requested by the attending physician, if provided by an accredited or certified program. Nutritional therapy is covered under the Nutritional Counseling benefit.

DIALYSIS

Dialysis Benefits are administered through Ameriben. For instructions for claiming benefits or for additional information on Covered Services, please contact the Plan Administrator or Ameriben.

Plan Administrator	Plan Benefits, Claims, Appeals, and Eligibility Information	Preauthorization (Including Preauthorization Appeals) and Case Management
Swire Pacific Holdings Inc. Swire Coca-Cola USA 12634 South 265 West Draper, UT 84020 (801) 816-5300	AmeriBen P.O. Box 7186 Boise, ID 83707 1 (866) 259-2405 www.MyAmeriBen.com	AmerBen Medical Management P.O. Box 7187 Boise, ID 83707 1 (866) 215-0975

The Claims Administrator, Regence BlueCross BlueShield of Utah assumes no liability for the accuracy of Your dialysis benefit information.

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home. Examples include oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

Additionally, the Plan covers Durable Medical Equipment that is obtained from an approved Commercial Seller. Benefits for eligible Durable Medical Equipment will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible Durable Medical Equipment, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit the Claims Administrator's Web site or contact Customer Service.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Provider: In-Network	Provider: Out-of-Network
Payment: After $75 Copayment per visit, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** After $75 Copayment per visit, the Plan pays 80% of the Allowed Amount and You pay balance of billed charges. Your 20% payment of the Allowed Amount will be applied toward the In-Network Out-of-Pocket Maximum. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.

The Plan covers emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. For the purpose of this benefit, "stabilization" means to provide Medically Necessary treatment: 1) to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during, or to result from, the transfer of the Claimant from a facility; and 2) in the case of a covered female Claimant, who is pregnant, to perform the delivery (including the placenta). Emergency room services do not need to be pre-authorized. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. However, You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Hospital Care benefit in this Medical Benefits Section for coverage of inpatient Hospital admissions.

FAMILY PLANNING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers certain professional Provider contraceptive services and supplies, including, but not limited to, vasectomy. See the Prescription Medication Benefits Section for coverage of prescription contraceptives.

Please see the Preventive Care and Immunizations benefit for coverage of women's contraceptive methods, sterilization procedures, and patient education and counseling services in accordance with any frequency guidelines according to, and as recommended by HRSA.

GENETIC TESTING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

NOTE: Genetic testing services may otherwise be covered under the Upfront Benefits for Outpatient Laboratory and Radiology Services benefit.

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 120 visits per Claimant per Calendar Year	

The Plan covers home health care when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Home health care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with home health care services is covered under the Durable Medical Equipment benefit in this Summary Plan Description.

HOSPICE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Respite Care limit: 14 inpatient or outpatient days per Claimant Lifetime **Hospice Care limit:** 180 inpatient or outpatient days per Claimant Lifetime	

The Plan covers hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of Illness. Respite care: The Plan covers respite care to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Hospice or respite days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered under the Durable Medical Equipment benefit in this Summary Plan Description.

HOSPITAL CARE – INPATIENT AND OUTPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers inpatient and outpatient services and supplies of a Hospital for Injury and Illness (including services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to a nonparticipating Hospital directly from the emergency room, services will be covered at the In-Network benefit level. However, You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Emergency Room benefit in this Medical Benefits Section for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

If benefits under the Plan change while You or a Beneficiary are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

INFERTILITY TREATMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers the surgical and nonsurgical treatment for the correction of infertility. This coverage does not include assisted reproductive procedures (for example, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception) or fertility drugs and medications.

MATERNITY CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions for all female Claimants. There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit in this Medical Benefits Section to see how the care of Your newborn is covered.

Certain services such as screening for gestational diabetes, breastfeeding support, supplies and counseling are covered under Your Preventive Care benefit.

Coverage for termination of pregnancy (abortion) will be provided for all female Claimants only for the following:

- when necessary to avert the death of the female Claimant on whom the abortion is performed; or
- where the female Claimant is pregnant as a result of rape, rape of a child or incest.

Surrogacy

Maternity and related medical services received by You while Acting as a Surrogate are not Covered Services, up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, You Acting as a Surrogate. By incurring and making claim for such services, You agree to reimburse the Claims Administrator the lesser of the amount described in the preceding sentence and the amount the Plan has paid for those Covered Services (even if payment or compensation to You or any other person or entity occurs after the termination of Your coverage under this Plan).

You must notify the Claims Administrator within 30 days of entering into any agreement to Act as a Surrogate and agree to cooperate with the Plan as needed to ensure the Claims Administrator's ability to recover the costs of Covered Services received by You for which the Plan is entitled to reimbursement. To notify the Claims Administrator, or to request additional information on Your responsibilities related to these notification and cooperation requirements, contact Customer Service. Please also refer to the Subrogation and Right of Recovery Section for more information.

Definitions

In addition to the definitions in the Definitions Section, the following definition applies to this Maternity Care benefit:

Acting (or Act) as a Surrogate means You agree to become pregnant and to surrender, relinquish or otherwise give up any parental rights to the baby (or babies) produced by that pregnancy to another person or persons who intend to raise the baby (or babies), whether or not You receive payment, the agreement is written and/or the parties to the agreement meet their obligations.

MEDICAL FOODS (PKU)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU).

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers Mental Health and Substance Use Disorder Services for treatment of Mental Health Conditions or Substance Use Disorders.

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Mental Health or Substance Use Disorder Services benefit:

Mental Health or Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health Provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is Medically Necessary).

Mental Health Conditions means mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association except as otherwise excluded in this Plan. Mental disorders that accompany an excluded diagnosis are covered.

Residential Care means care received in an organized program which is provided by a residential facility, Hospital, or other facility licensed, for the particular level of care for which reimbursement is being sought, by the state in which the treatment is provided.

Substance Use Disorders means substance-related disorders included in the most recent edition of the DSM. Substance Use Disorder does not include addiction to or dependency on tobacco, tobacco products or foods.

NEURODEVELOPMENTAL THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Inpatient limit: unlimited **Outpatient limit:** 40 visits per Claimant per Calendar Year for all outpatient neurodevelopmental therapy services	

The Plan covers inpatient and outpatient neurodevelopmental therapy services. To be covered, such services must be to restore or improve function for a Claimant age six and under with a neurodevelopmental delay. For the purpose of this benefit, "neurodevelopmental delay" means a delay in normal development that is not related to any documented Illness or Injury. Covered Services include only physical therapy, occupational therapy and speech therapy and maintenance services, if significant deterioration of the Claimant's condition would result without the service. You will not be eligible for both the Rehabilitative Services benefit and this benefit for the same services for the same condition. Outpatient neurodevelopmental therapy visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services and supplies, under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child. The newborn child must be eligible and enrolled as explained later in the Who Is Eligible, How to Enroll and When Coverage Begins Section. There is no limit for the newborn's length of inpatient stay. For the purpose of this benefit, "newborn care" means the medical services provided to a newborn child following birth including Hospital nursery charges, the initial physical examination and a PKU test.

NUTRITIONAL COUNSELING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: three visits per Claimant Lifetime (diabetic counseling is not subject to this limit).	

The Plan covers outpatient nutritional counseling, therapy and diabetic counseling. Nutritional counseling visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers benefits for the purchase of braces, splints, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body. The Plan may elect to provide benefits for a less costly alternative item. The Plan does not cover off-the-shelf shoe inserts and orthopedic shoes.

Additionally, the Plan covers certain orthotic devices that are obtained from an approved Commercial Seller. Benefits for eligible orthotic devices will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible orthotic devices, find an approved Commercial Seller, instructions for claiming benefits or for the additional information on Covered Services, please visit the Claims Administrator's Web site or contact Customer Service.

PALLIATIVE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 30 visits per Claimant per Calendar Year	

The Plan covers palliative care when a Provider has assessed that a Claimant is in need of palliative services. For the purpose of this benefit, "palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living. Palliative care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

PRIVATE-DUTY NURSING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: $2,500 per Claimant per Calendar Year	

The Plan covers private-duty nursing, including ongoing shift care in the home.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility benefit (Hospital Care or Ambulatory Surgical Center) in this Medical Benefits Section. The Plan will cover repair or replacement of a prosthetic device due to normal use or growth of a child.

REHABILITATION SERVICES

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 40 days per Claimant per Calendar Year	

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Occupational and physical therapy limit: unlimited **Pulmonary therapy limit:** 30 visits per Claimant per Calendar Year **Speech therapy limit:** 20 visits per Claimant per Calendar Year	

The Plan covers inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness. Rehabilitation days or visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the neurodevelopmental therapy benefit and this benefit for the same services for the same condition.

REPAIR OF TEETH

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services and supplies for treatment required as a result of damage to or loss of sound natural teeth when such damage or loss is due to an Injury.

SKILLED NURSING FACILITY (SNF) CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 60 inpatient days per Claimant per Calendar Year	

The Plan covers the inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary. Skilled Nursing Facility days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, Prescription Medications, and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward any Maximum Benefit limit on Skilled Nursing Facility care.

SPINAL MANIPULATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount. Your 50% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: $1,500 per Claimant per Calendar Year	

The Plan covers spinal manipulations performed by any Provider. Manipulations of extremities are covered under the Neurodevelopmental Therapy and Rehabilitation Services benefits in this Medical Benefits Section.

TELEMEDICINE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers telemedicine (audio and video communication) services between a distant-site Practitioner and a patient at an originating site. Originating sites include facilities such as Hospitals, rural health clinics, Physician's offices and community mental health centers.

The Plan also covers store and forward technology. For the purpose of this benefit, "store and forward technology" is secure one-way electronic transmission (sending) of a patient's medical information from an originating site to a Provider at a distant site, which is later used by the Provider for diagnosis and medical management of the patient. Store and forward technology does not include telephone, fax or e-mail communication.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers inpatient and outpatient services for treatment of temporomandibular joint (TMJ) disorders which have one or more of the following characteristics:

- an abnormal range of motion or limitation of motion of the TMJ;
- arthritic problems with the TMJ;
- internal derangement of the TMJ; and/or
- pain in the musculature associated with the TMJ.

"Covered services" for the purpose of this TMJ benefit, mean those services that are:

- reasonable and appropriate for the treatment of a disorder of the TMJ, under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the TMJ: pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food;
- recognized as effective, according to the professional standards of good medical practice; and
- not Investigational or primarily for Cosmetic purposes.

TRANSPLANTS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers transplants, including transplant-related services and supplies for covered transplants. A transplant recipient who is covered under this plan and fulfills Medically Necessary criteria will be eligible for the following transplants: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell and hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors, for example, either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions). This list of transplants is subject to change. Claimants can contact the Claims Administrator for a current list of covered transplants.

Donor Organ Benefits

This Plan covers donor organ procurement costs if the recipient is covered for the transplant under this plan. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such procurement costs that the Plan determines.

Prescription Medication Benefits

In this section, You will learn how Your Prescription Medication coverage works, including information about Deductibles (if any), Copayments, Coinsurance, Covered Services and payment, as well as definitions of terms specific to this Prescription Medication Benefits Section.

All terms and conditions of the Plan apply to this Prescription Medication Benefits Section, except as otherwise noted. Benefits will be paid under this Prescription Medication Benefits Section, not any other provision in this Summary Plan Description, if a medication or supply is covered under both.

PRESCRIPTION MEDICATION CALENDAR YEAR DEDUCTIBLES

Per Claimant: $50
Per Family: $150

You do not need to meet the Prescription Medication Deductible when You fill a prescription for a Generic Medication. You also do not need to meet the Deductible when You fill a prescription for a Self-Administrable Cancer Chemotherapy Medication.

This Prescription Medication Deductible is calculated separately from any other Deductible in the Plan. However, this Prescription Medication Deductible will be applied toward the Out-of-Pocket Maximum as further specified in the Understanding Your Benefits Section in this Summary Plan Description. Any costs in excess of the Covered Prescription Medication Expense that are charged by a Nonparticipating Pharmacy do not count toward the Prescription Medication Deductible. In addition, the difference between the price of a Brand-Name Medication and its generic equivalent do not count toward the Prescription Medication Deductible.

COPAYMENTS AND COINSURANCE

After You meet any applicable Deductible, You are responsible for paying the following Copayment and/or Coinsurance amounts (at the time of purchase, if the Pharmacy submits the claim electronically). (See below for information on claims that are not submitted electronically and for information on maximum quantities.)

For Prescription Medications from a Pharmacy

• $10 for each Generic Medication.
• $30 for each Brand-Name Medication on the Formulary.
• $50 for each Brand-Name Medication not on the Formulary.

For Prescription Medications from a Mail-Order Supplier

• $20 for each Generic Medication.
• $75 for each Brand-Name Medication on the Formulary.
• $125 for each Brand-Name Medication not on the Formulary.

For Prescription Medications from a Specialty Pharmacy

• $50 for each Specialty Medication.

Brand-Name Prescription Medication Instead of Generic

If an equivalent Generic Medication is available and You choose to fill a Prescription Order with a Brand-Name Medication, even if the prescribing Provider specifies that the Brand-Name Medication must be dispensed, You will be responsible for paying the difference in cost (which does not count toward Your Deductible (if applicable) or any Out-of-Pocket Maximum). The difference is calculated at the time of purchase based upon the difference in price between the equivalent Generic Medication and the applicable Brand-Name Medication, in addition to the Copayment and/or Coinsurance (as applicable). NOTE: See the Covered Prescription Medications provision below for an exception that applies to covered preventive medications, including women's contraceptives.

PRESCRIPTION MEDICATION CALENDAR YEAR OUT-OF-POCKET MAXIMUM
Not applicable

COVERED PRESCRIPTION MEDICATIONS
Benefits under this Prescription Medication Benefits Section are available for the following:

- diabetic supplies (including test strips, glucagon emergency kits, insulin syringes, but not insulin pumps and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- certain preventive medications (including, but not limited to, aspirin, fluoride, iron and medications for tobacco use cessation) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- FDA-approved women's prescription and over-the-counter (if presented with a Prescription Order) contraception methods as recommended by the HRSA. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, and emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products);
- immunizations for adults and children according to, and as recommended by, the CDC;
- Prescription medications for sexual dysfunction, limited to 6 pills per month;
- Specialty Medications;
- Self-Administrable Cancer Chemotherapy Medication (all Prescription Medications for Self-Administrable Cancer Chemotherapy Medications must be provided by a Specialty Pharmacy). See below for Special Provisions for a Cancer Drug Treatment Regimen; and
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications).

You are not responsible for any applicable Deductible, Copayment and/or Coinsurance when You fill prescriptions at a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications, women's contraceptives, or for immunizations, as specified above. For a list of such medications, please visit the Claims Administrator's Web site or contact Customer Service. Also, if Your Provider believes that the Plan's covered preventive medications, including women's contraceptives, are medically inappropriate for You, You may request a coverage exception for a different preventive medication by contacting the Claims Administrator's Customer Service. NOTE: The applicable Deductible, Copayment and/or Coinsurance as listed in this Prescription Medication Benefits Section will apply when You fill preventive medications and immunizations that meet the above criteria, at a Nonparticipating Pharmacy.

GENERAL PRESCRIPTION MEDICATION BENEFITS INFORMATION (NETWORK, SUBMISSION OF CLAIMS AND MAIL-ORDER)
A nationwide network of Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically.

Your Plan identification card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as a Claimant under this Plan, a Participating Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Participating Pharmacies and a Pharmacy locator on the Claims Administrator's Web site or by contacting Customer Service.

Special Provisions for a Cancer Drug Treatment Regimen
Prescription Medications used as part of a cancer drug treatment regimen for a cancer patient who is undergoing chemotherapy in an outpatient clinic setting, will be covered subject to the same benefits, limitations and exclusions of this Prescription Medication Benefits Section, when dispensed through a professional Provider who meets the requirements set forth in Utah Code 58-17b-309 & 309.5. For purposes of this provision, a "cancer drug treatment regimen" means a Prescription Medication used to treat cancer, manage its symptoms, or provide continuity of care for a cancer patient.

Prescription Medications eligible for dispensing through a professional Provider's office include a chemotherapy drug administered orally, rectally or by dermal methods and medication used to support cancer treatment (including to treat, alleviate or minimize physical and psychological symptoms of pain, to improve patient tolerance of cancer treatments, or prepare a patient for a subsequent course of therapy). Any Prescription Medication listed under federal law as a Schedule I, II, or III drug is not eligible for this special dispensing provision. Intravenous medications are otherwise covered under the applicable Medical Benefits Section(s). You can find a list of Prescription Medications eligible for dispensing through a professional Provider's office on the Claims Administrator's Web site.

Claims Submitted Electronically

You must present Your Plan identification card at a Pharmacy for the claim to be submitted electronically. You must pay any required Deductible, Copayment and/or Coinsurance at the time of purchase. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, The Claims Administrator will pay the Nonparticipating Pharmacy directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well as any Deductible, Copayment and/or Coinsurance shown electronically to the Nonparticipating Pharmacy at the time of purchase.

Claims Not Submitted Electronically

When a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, simply complete a Prescription Medication claim form and mail the form and receipt to the Claims Administrator. The Claims Administrator will reimburse You based on the Covered Prescription Medication Expense, less the applicable Deductible, Copayment and/or Coinsurance that would have been required had the medication been purchased from and submitted electronically by a Participating Pharmacy. The Claims Administrator will send payment directly to You.

It is best to use a Participating Pharmacy so Your claims can be submitted electronically, and so You won't have to pay the difference between the Pharmacy's charges and the Covered Prescription Medication Expense in addition to Your Deductible, Copayment and/or Coinsurance.

Mail-Order

You can also use mail-order services to purchase covered Prescription Medications. Mail-order coverage applies only when Prescription Medications are purchased from a Mail-Order Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Mail-Order Suppliers.

To buy Prescription Medications through the mail, simply send all of the following items to a Mail-Order Supplier at the address shown on the prescription mail-order form available on the Claims Administrator's Web site or from the Plan Sponsor (which also includes refill instructions):

- a completed prescription mail-order form;
- any Deductible, Copayment and/or Coinsurance; and
- the original Prescription Order.

PREAUTHORIZATION

Preauthorization may be required to establish that a Prescription Medication is Medically Necessary before it is dispensed. The Claims Administrator publishes a list of those medications that currently require preauthorization. If You have any questions regarding the list of medications that require preauthorization, You can contact Customer Service or view the list on their Web site. In addition, participating Providers, including Pharmacies, are notified which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to determine Medical Necessity of Prescription Medications that require preauthorization.

Coverage for preauthorized Prescribed Medications begins on the date the Claims Administrator preauthorizes them. If Your Prescription Medication requires preauthorization and You purchase it before the Claims Administrator preauthorizes it or without obtaining the preauthorization, the Prescription Medication may not be covered, even if purchased from a Participating Pharmacy.

LIMITATIONS

The following limitations apply to this Prescription Medication Benefits Section, except for certain preventive medications as specified in the Covered Prescription Medications Section:

Maximum 30-Day or Greater Supply Limit

- **Injectable Medications and 90-Day Supply.** The largest allowable quantity for Self-Administrable Injectable Medications purchased from a Pharmacy or Mail-Order Supplier, is a 90-day supply. The Copayment and/or Coinsurance for Self-Administrable Injectable Medications purchased from a Mail-Order Supplier will be the same as if the medication was purchased from and the claim was submitted electronically by a Pharmacy.
- **Specialty Medications and 30-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Specialty Pharmacy, is a 30-day supply. The first fill for Specialty Medications (including those on the Specialty Select Drug List) is allowed at a Pharmacy. Additional fills must be provided at a Specialty Pharmacy, however some Specialty Medications must have the first and subsequent fills at a Specialty Pharmacy. For more information on those medications, please visit the Claims Administrator's Web site or contact Customer Service. Specialty Medications are not allowed through mail-order.
- **Mail-Order and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities. Self-Administrable Injectable Medications are limited to a 30-day supply as indicated above.
- **Pharmacy and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Pharmacy is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities.
- **Pharmacy and 90-Day Multiple-Month Supply.** The largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Pharmacy is the smallest multiple-month supply packaged by the manufacturer for dispensing by Pharmacies. The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The maximum supply covered for these products is a 90-day supply (even if the packaging includes a larger supply). The Copayment and/or Coinsurance is based on each 30-day supply within that multiple-month supply.

Maximum Quantity Limit

For certain Prescription Medications, the Claims Administrator establishes maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. The Claims Administrator uses information from the United States Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your Plan identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service. The Plan does not cover any amount over the established maximum quantity, except if it is determined the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

Refills

The Plan will cover refills from a Pharmacy when You have taken 75 percent of the previous prescription (however, based upon state law, certain controlled substances may be refilled only after You have taken 80 percent of the previous prescription). Refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward Your Deductible (if applicable) or any Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered at the Claims Administrator's discretion on a case-by-case basis. You may request an exception by calling Customer Service.

Prescription Medications Dispensed by Excluded Pharmacies
A Pharmacy may be excluded if it has been investigated by the Office of the Inspector General (OIG) and appears on the OIG's exclusion list. If You are receiving medications from a Pharmacy that is later determined by the OIG to be an excluded Pharmacy, You will be notified, after Your claim has been processed, that the Pharmacy has been excluded, so that You may obtain future Prescription Medications from a non-excluded Pharmacy. The Claims Administrator does not permit excluded Pharmacies to submit claims after the excluded Pharmacies have been added to the OIG list.

EXCLUSIONS
In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Prescription Medication Benefits Section:

Biological Sera, Blood or Blood Plasma, Plasma-derived and Recombinant Clotting Factor Products

Cosmetic Purposes
Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; anti-aging; repair of sun-damaged skin; or reduction in redness associated with rosacea.

Devices or Appliances
Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Medical Benefits Section).

Foreign Prescription Medications
Except for Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States, or Prescription Medications You purchase while residing outside the United States, the Plan does not cover foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.

Insulin Pumps and Pump Administration Supplies
Coverage for insulin pumps and supplies is provided under the Medical Benefits Section.

Medications The Plan Does not Consider Self-Administrable
Coverage for these medications may otherwise be provided under the Medical Benefits Section.

Nonprescription Medications
Except for medications included on the Claims Administrator's Formulary, approved by the FDA or a Prescription Order by a Physician or Practitioner, the Plan does not cover medications that by law do not require a Prescription Order, for example, over-the-counter medications, including vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements.

Prescription Medications Dispensed in a Facility
Prescription Medications dispensed to You while You are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.

Prescription Medications for Treatment of Infertility

Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order

Prescription Medications Not within a Provider's License
Prescription Medications prescribed by Providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

Prescription Medications with Lower Cost Alternatives
Except for higher cost Prescription Medications that are Medically Necessary, the Plan does not cover Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives or over-the-counter (nonprescription) alternatives.

Prescription Medications without Examination
Except as provided under the Telemedicine benefit in the Medical Benefits Section the Plan does not cover prescriptions made by a Provider without recent and relevant in-person examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe an opioid antagonist to a Claimant who is at risk of experiencing an opiate-related overdose.

Professional Charges for Administration of Any Medication

DEFINITIONS
In addition to the definitions in the Definitions Section, the following definitions apply to this Prescription Medication Benefits Section:

Brand-Name Medication means a Prescription Medication that is marketed and sold by limited sources or is listed in widely accepted references (or as specified by the Claims Administrator) as a Brand-Name Medication based on manufacturer and price.

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a Prescription Medication that has been approved by the FDA and may be subject to review for Medical Necessity.

Covered Prescription Medication Expense means the total payment a Participating Pharmacy or Mail-Order Supplier has contractually agreed to accept as full payment for a Prescription Medication. A Participating Pharmacy or Mail-Order Supplier may not charge You more than the Covered Prescription Medication Expense for a Prescription Medication.

Formulary means the Claims Administrator's list of selected Prescription Medications. The Claims Administrator established and routinely reviews and updates the Formulary. It is available on the Claims Administrator's Web site or contact Customer Service. Medications are reviewed and selected for inclusion in the Formulary by an outside committee of Providers, including Physicians and Pharmacists.

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references (or specified by the Claims Administrator) as a Generic Medication. For the purpose of this definition, "equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards, and is as safe and as effective as the Brand-Name Medication. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, the Claims Administrator will decide.

Mail-Order Supplier means a mail-order Pharmacy with which the Claims Administrator has contracted for mail-order services.

Pharmacist means an individual licensed to dispense Prescription Medications, counsel a patient about how the medication works and its possible adverse effects and perform other duties as described in his or her state's Pharmacy practice act.

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed. A Participating Pharmacy means either a Pharmacy with which the Claims Administrator has a contract or a Pharmacy that participates in a network for which the Claims Administrator has contracted to have access. Participating Pharmacies have the capability of submitting claims electronically. A

Nonparticipating Pharmacy means a Pharmacy with which the Claims Administrator neither has a contract nor has contracted access to any network it belongs to. Nonparticipating Pharmacies may not be able to or choose not to submit claims electronically.

Prescription Medications (also Prescribed Medications) means medications and biologicals that relate directly to the treatment of an Illness or Injury, legally cannot be dispensed without a Prescription Order and by law must bear the legend: "Prescription Only," or as specifically included the Claims Administrator's Formulary.

Prescription Order means a written prescription or oral request for Prescription Medications issued by a Provider who is licensed to prescribe medications.

Self-Administrable Prescription Medications (also Self-Administrable Medications, or Self-Administrable Injectable Medication, or Self-Administrable Cancer Chemotherapy Medication) means, a Prescription Medication (including, for Self-Administrable Cancer Chemotherapy Medication, oral Prescription Medication including those used to kill or slow the growth of cancerous cells), determined by the Claims Administrator, which can be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician office or clinic) and that does not require administration by a Provider. In determining what are considered Self-Administrable Medications, the Claims Administrator refers to information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that is considered a relevant and reliable indication of safety and acceptability. Your status, such as Your ability to administer the medication, will not be considered when determining whether a medication is self-administrable.

Specialty Medications means medications used for patients with complex disease states, such as but not limited to multiple sclerosis, rheumatoid arthritis, cancer and hepatitis C. For a list of some of these medications, please visit the Claims Administrator's Web site or contact Customer Service.

Specialty Pharmacy means a Pharmacy that specializes in the distribution and medication management services of high cost injectable and Specialty Medications. To find a Specialty Pharmacy, please visit the Claims Administrator's Web site or contact Customer Service.

Care Management and Wellness Programs

Because of Regence's involvement as the Claims Administrator, You have access to the following group-sponsored care management and wellness programs. Your employer has chosen to provide these benefits to You. To the extent any part of these programs (for example, medications for smoking cessation) is also a benefit under the Medical Benefits or other benefit of the Plan, the Medical Benefits or other benefit applies first and until that benefit is exhausted.

CASE MANAGEMENT

Receive one-on-one help and support in the event You have a serious or sudden Illness or Injury. An experienced, compassionate case manager will serve as Your personal advocate during a time when You need it most. Your case manager is a licensed health care professional who will help You understand Your treatment options, show You how to get the most out of Your available Plan benefits and work with Your Physician to support Your treatment plan.

To learn more or to make a referral to case management, please call 1 (866) 543-5765.

REGENCE CONDITION MANAGER

Regence Condition Manager is a support and education program for people with chronic conditions such as diabetes, heart disease, asthma and/or depression. The Claims Administrator's nurses and behavioral health care coordinators provide tailored educational materials, tools and other services to help You get on track with Your care--and stay there. They can help You understand the care plan You've developed with Your Physician, and make smarter choices for better health.

To learn more, please call 1 (866) 543-5765.

REGENCE ADVICE24

Registered nurses are available 24/7 to answer Your health-related questions and help You make informed decisions about when, where and if to seek care. If You're not sure whether to visit the emergency room, see Your doctor or treat Your condition at home, the nurses are there, day or night.

Regence Advice24 nurses have access to information about more than 5,500 health topics to ensure you receive the right care.

Call the Advice24 hotline any time-24 hours a day, seven days a week at 1 (800) 267-6729.

General Exclusions

The following are the general exclusions from coverage under the Plan. Other exclusions may apply and, if so, will be described elsewhere in this Summary Plan Description.

PREEXISTING CONDITIONS

This coverage does not have an exclusion period for Preexisting Conditions. A Preexisting Condition normally means a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within a specified period of time before the enrollment date.

EXCLUSION EXAMPLES

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under the Plan, including related secondary medical conditions, and are not all inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications relating to services and supplies for, or in connection with, gastric or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for, or in connection with, reversal or revision of such procedures, or any direct complications or consequences thereof;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
  - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an Injury or Illness resulting from active participation in illegal activities.

SPECIFIC EXCLUSIONS

The Plan will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise Covered Service for: 1) an Injury if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law; or 2) a preventive service as specified under the Preventive Care and Immunizations benefit in the Medical Benefits Section or in the Prescription Medication Benefits Section.

Activity Therapy

Creative arts, play, dance, aroma, music, equine or other animal-assisted, recreational or similar therapy; sensory movement groups; and wilderness or adventure programs.

Assisted Reproductive Technologies

Assisted reproductive technologies (including, but not limited to, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), or associated surgery, drugs, testing or supplies, regardless of underlying condition or circumstance.

Certain Therapy, Counseling and Training

Educational, vocational, social, image, milieu or marathon group therapy, premarital or marital counseling, Employee Assistance Program (EAP) services, except as provided under the EAP Section, if applicable; job skills or sensitivity training.

Complementary Care

Complementary care, including, but not limited to, acupuncture.

Conditions Caused By Active Participation In a War or Insurrection

The treatment of any condition caused by or arising out of a Claimant's active participation in a war or insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services
The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Cosmetic/Reconstructive Services and Supplies
Cosmetic and/or reconstructive services and supplies, except in the treatment of the following:

- to treat a congenital anomaly for Claimants up to age 26;
- to restore a physical bodily function lost as a result of Injury or Illness; or
- related to breast reconstruction following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice in this Summary Plan Description.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Counseling in the Absence of Illness
Except as required by law, the Plan does not cover counseling in the absence of Illness.

Custodial Care
Except as provided under the Palliative Care benefit in this Summary Plan Description, the Plan does not cover non-skilled care and helping with activities of daily living.

Dental Services
Except as provided under the Repair of Teeth benefit in this Summary Plan Description, the Plan does not cover Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before Your Effective Date under the Plan or after Your termination under the Plan.

Family Counseling
Except when family counseling is part of the treatment for a child or adolescent with a covered diagnosis, the Plan does not cover family counseling.

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. The Plan also does not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Government Programs
Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with the Claims Administrator and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. Expenses from government facilities outside the service area are not covered under the Plan (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

Growth Hormone Therapy
Except as provided under the Prescription Medications benefit in this Summary Plan Description, the Plan does not cover growth hormone therapy.

Hearing Aids and Other Devices
Except for cochlear implants, the Plan does not cover hearing aids (externally worn or surgically implanted) or other hearing devices.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses, including, but not limited to, use of such services for the treatment of painful physical conditions, Mental Health Conditions, Substance Use Disorders or for anesthesia purposes.

Illegal Services, Substances and Supplies
Services, substances and supplies that are illegal as defined under state or federal law.

Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports as provided under an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility
Except as provided under the Infertility Treatment benefit in this Summary Plan Description or to the extent Covered Services are required to diagnose such condition, the Plan does not cover treatment of infertility, including, but not limited to, surgery, fertility drugs and medications.

Investigational Services
Except as provided under the Approved Clinical trials benefit in this Summary Plan Description, the Plan does not cover Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section in this Summary Plan Description.

Motor Vehicle Coverage and Other Available Insurance
Expenses for services and supplies that are payable under any automobile medical, personal injury protection (PIP), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to this Summary Plan Description.

Non-Direct Patient Care
Services that are not direct patient care, including:

- appointments scheduled and not kept (missed appointments);
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at the Claims Administrator's request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges), except as provided under the Telemedicine benefit.

Obesity or Weight Reduction/Control
Except as may be provided in this Summary Plan Description or as required by law, the Plan does not cover medical treatment, medication, surgical treatment (including treatment of complications, revisions and reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

Orthognathic Surgery
Except for orthognathic surgery due to an Injury, temporomandibular joint disorder, sleep apnea or congenital anomaly, the Plan does not cover services and supplies for orthognathic surgery. Orthognathic surgery means surgery to manipulate facial bones, including the jaw, in patients with facial

bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones.

Over-the-Counter Contraceptives
Except as provided under the Prescription Medication Benefits Section in this Summary Plan Description or as required by law, the Plan does not cover over-the-counter contraceptive supplies.

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control, education or general physical health. For example, the Plan does not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, weight lifting equipment, physical fitness programs and therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment, including hot tubs or membership fees at spas, health clubs or other such facilities. This exclusion applies even if the program, equipment or membership is recommended by the Claimant's Provider.

Reversals of Sterilizations
Services and supplies related to reversals of sterilization.

Riot, Rebellion and Illegal Acts
Services and supplies for treatment of an Illness, Injury or condition caused by a Claimant's **voluntary participation in** a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Claimant arising directly from an act deemed illegal by an officer or a court of law.

Routine Foot Care
Except for foot care associated with diabetes, the Plan does not cover routine foot care.

Routine Hearing Examinations

Self-Help, Self-Care, Training or Instructional Programs
Self-help, non-medical self-care and training programs, including:

- childbirth-related classes including infant care; and
- instruction programs including those that teach a person how to use Durable Medical Equipment or how to care for a family member.

This exclusion does not apply to services for training or educating a Claimant when provided without separate charge in connection with Covered Services or when specifically indicated as a Covered Service in the Medical Benefits Section (for example, nutritional counseling, diabetic education and teaching doses for Self-Administrable Injectable Medications).

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings;
- Your child's or stepchild's spouse or domestic partner; and
- any other of Your relatives by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary
Except for preventive care benefits provided in this Summary Plan Description, the Plan does not cover services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Sexual Dysfunction
Except for covered Mental Health Conditions or under the Prescription Medications Benefits provided in this Summary Plan Description, the Plan does not cover treatment, services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.

Surrogacy
Maternity and related medical services received by You Acting as a Surrogate are not Covered Services up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, Your Acting as a Surrogate. For purpose of this exclusion, "maternity and related medical services" includes otherwise Covered Services for conception, prenatal, maternity, delivery and postpartum care. Please refer to the Maternity Care and/or Subrogation and Right of Recovery Sections for more information.

Telehealth

Termination of Pregnancy (Abortion)
Except as provided under the Maternity Care Benefit in this Summary Plan Description, the Plan does not cover services or supplies related to the termination of a pregnancy (abortion).

Third-Party Liability
Services and supplies for treatment of Illness or Injury for which a third-party is or may be responsible.

Travel and Transportation Expenses
Travel and transportation expenses other than covered ambulance services provided in this Summary Plan Description.

Travel Immunizations
Immunizations for purposes of travel, occupation or residency in a foreign country.

Varicose Vein Treatment
Except when there is associated venous ulceration or persistent or recurrent bleeding from ruptured veins, the Plan does not cover treatment of varicose veins.

Vision Care
The Plan does not cover routine eye exam and vision hardware.

Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.

Work-Related Conditions
Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. The Claims Administrator may require the Claimant to file a claim for workers' compensation benefits before providing any benefits under this coverage. The Plan does not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if a Claimant is exempt from state or federal workers' compensation law. This exclusion shall also apply if You or Your Beneficiaries opt out of workers' compensation.

Claims Administration

This section explains a variety of matters related to administering benefits and/or claims, including situations that may arise when Your health care expenses are the responsibility of a source other than the Plan.

PREAUTHORIZATION

Preauthorization refers to the process by which the Claims Administrator determines that a proposed service or supply is Medically Necessary and provide approval for it before it is rendered.

Preauthorization is performed to ensure that the services You receive are aligned with evidence based criteria and to determine whether the requested service meets the Claims Administrator's Medical Necessity criteria. Preauthorization also ensures that services or supplies You receive are safe, effective and appropriate, with the goal of helping You obtain the most out of Your health plan benefits and receiving the right care, at the right time and in the right place.

Contracted Providers may be required to obtain preauthorization from the Claims Administrator in advance for certain services provided to You. Non-contracted Providers are not required to obtain preauthorization from the Claims Administrator in advance for services. You, however, may be liable for costs if You elect to seek services and those services are not considered Medically Necessary and/or not covered under this Plan. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to the services being rendered.

A comprehensive list of services and supplies that must be preauthorized may be obtained from the Claims Administrator by visiting the Claims Administrator's Web site at: **regence.com/web/regence_provider/pre-authorization** or by calling Customer Service.

Preauthorization requests should be faxed by Your Provider following the instructions on the Claims Administrator's Web site listed above.

Time Frame for Response

You will be notified in writing within 15 calendar days of the Claims Administrator's receipt of the preauthorization request whether the request has been approved, denied or if more information is needed to make a determination.

When More Information is Needed to Make a Determination

Additional information requested by the Claims Administrator must be received within 45 calendar days of the date on the letter requesting information. The Claims Administrator will notify You in writing of the determination within 15 calendar days of receipt of additional information or within 15 calendar days of the end of the 45 day period if no additional information is received.

If You or Your Physician believes that waiting for a determination under the standard time frame could place Your life, health or ability to regain maximum function in serious jeopardy, Your Physician should notify the Claims Administrator by phone or fax as a shorter time frame for response may apply.

Preauthorization does not guarantee payment. The Claim Administrator's reimbursement policies may affect how claims are reimbursed, and payment of benefits is subject to all Plan provisions, including eligibility for benefits at the time of services.

PLAN IDENTIFICATION CARD

When Participants enroll in the Plan, they will receive Plan identification cards. The identification card will include important information such as the Participant's identification number, group number and name.

It is important to keep Your Plan identification card with You at all times. Be sure to present it to Your Provider before receiving care.

If You lose Your card, or if it gets destroyed, You can get a new one by contacting Customer Service. You can also view or print an image of Your Plan identification card by visiting the Claims Administrator's

Web site on Your PC or mobile device. If the Agreement terminates, Your Plan identification card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

The Claims Administrator will decide whether to pay You, the Provider or You and the Provider jointly. Benefit payments may be made for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.

Claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the locale in which the equipment was received. Durable Medical Equipment is received where it is purchased at retail or, if shipped, where the Durable Medical Equipment is shipped to. Please refer to Your Blue plan network where supplies were received for coverage of shipped Durable Medical Equipment.

Claims for independent clinical laboratory services will be submitted to the Blue plan in the locale in which the specimen was drawn or otherwise acquired, regardless of where the examination of the specimen occurred. Please refer to Your Blue plan network where the specimen was drawn for coverage of independent clinical laboratory services.

You will be responsible for the total billed charges for benefits in excess of Maximum Benefits, if any, and for charges for any other service or supply not covered under this Plan, regardless of the Provider rendering such service or supply.

Calendar Year and Plan Year

The Deductible and Out-of-Pocket Maximum provisions are calculated on a Calendar Year basis. The Agreement is renewed, with or without changes, each Plan Year. A Plan Year is the 12-month period following either the Agreement's original Effective Date or subsequent renewal date. A Plan Year may or may not be the same as a Calendar Year. When the Agreement renews on other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the date the Agreement renews will be carried over into the next Plan Year. If the Deductible and/or Out-of-Pocket Maximum amount increases during the Calendar Year, You will need to meet the new requirement minus any amount You already satisfied under the previous Agreement during that same Calendar Year.

Timely Filing of Claims

Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. A claim that is not filed in a timely manner will be denied unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may, however, Appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner. (If You were covered by more than one health plan on the date of service, see the text of Secondary Health Plan in the Coordination of Benefits provision for an exception to this timely filing rule.)

Freedom of Choice of Provider

Nothing contained in this Summary Plan Description is designed to restrict You in selecting the Provider of Your choice for care or treatment of an Illness or Injury.

In-Network Provider Claims

You must present Your Plan identification card when obtaining Covered Services from an In-Network Provider. You must also furnish any additional information requested. The Provider will furnish the Claims Administrator with the forms and information needed to process Your claim.

In-Network Provider Reimbursement

The Plan will pay an In-Network Provider directly for Covered Services. These Providers have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Deductible, Copayment and/or Coinsurance. These Providers may require You to pay Your share at the time You receive care or treatment.

Out-of-Network Provider Claims

In order for the Claims Administrator to pay for Covered Services, You or the Out-of-Network Provider must first send the Claims Administrator a claim. Be sure the claim is complete and includes the following information:

- an itemized description of the services given and the charges for them;
- the date treatment was given;
- the diagnosis; and
- the patient's name and the group and identification numbers.

If the treatment is for an Injury, include a statement explaining the date, time, place and circumstances of the Injury when You send the Claims Administrator the claim.

Out-of-Network Provider Reimbursement

In most cases You will be paid directly for Covered Services provided by an Out-of-Network Provider.

Out-of-Network Providers have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, You are responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment and/or Coinsurance. For Out-of-Network Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

Reimbursement Examples by Provider

Here is an example of how Your selection of In-Network or Out-of-Network Providers affects payment to Providers and Your cost sharing amount. For purposes of this example, let's assume the Plan pays 80 percent of the Allowed Amount for In-Network Providers and 60 percent of the Allowed Amount for Out-of-Network Providers. The benefit table from the Medical Benefits Section (or other benefits section) would appear as follows:

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Now, let's assume that the Provider's charge for a service is $5,000 and the Allowed Amount for that charge is $4,000 for an In-Network Provider. Finally, the Plan will assume that You have met the Deductible and that You have not met the Out-of-Pocket Maximum. Here's how that Covered Service would be paid:

- In-Network Provider: the Plan would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:

  - Amount In-Network Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount the Plan pays (80% of the $4,000 Allowed Amount): $3,200
  - **Amount You pay** (20% of the $4,000 Allowed Amount): **$800**
  - Total: $5,000

- Out-of-Network Provider: the Plan would pay 60 percent of the Allowed Amount. Because the Out-of-Network Provider does not accept the Allowed Amount, You would pay 40 percent of the Allowed Amount, plus the $1,000 difference between the Out-of-Network Provider's billed charges and the Allowed Amount, as follows:

  - Amount the Plan pays (60% of the $4,000 Allowed Amount): $2,400
  - **Amount You pay** (40% of the $4,000 Allowed Amount and the $1,000 difference between the billed charges and the Allowed Amount): **$2,600**

- Total: $5,000

The actual benefits in the Plan may vary, so please read the benefits sections thoroughly to determine how Your benefits are paid. For example, as explained in the Definitions Section, the Allowed Amount may vary for a Covered Service depending upon Your selected Provider.

Ambulance Claims

When You or Your Provider forwards a claim for ambulance services to the Claims Administrator, it must show where the patient was picked up and where he or she was taken. It should also show the date of service, the patient's name and the patient's group and identification numbers.

Claims Determinations

Within 30 days of the Claims Administrator's receipt of a claim, You will be notified of the action taken on it. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When action cannot be taken on the claim due to circumstances beyond the Claims Administrator's control, they will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when the Claims Administrator expects to act on the claim.
- When action cannot be taken on the claim due to lack of information, the Claims Administrator will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

If the Claims Administrator seeks additional information from You, You will be allowed at least 45 days to provide the additional information. If the Claims Administrator does not receive the requested information to process the claim within the time allowed, the claim will be denied.

OUT-OF-AREA SERVICES

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever You access health care services outside the geographic area the Claims Administrator serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When care is received outside of the Claims Administrator's service area it will be received from one of two kinds of Providers. Most Providers ("In-Network Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Out-of-Network Providers") don't contract with the Host Blue. This section explains below how the Plan pays both kinds of Providers.

BlueCard Program

Under the BlueCard Program, when You access Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what the Claims Administrator agreed to in the Plan. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever You receive Covered Services outside the Claims Administrator's service area, and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price the Claims Administrator has used for Your claim because they will not be applied after a claim has already been paid.

Value-Based Programs
If You receive Covered Services under a Value-Based Program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordination Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

For the purpose of this section, the following definitions apply.

- Value-Based Program: An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.
- Provider Incentive: An additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.
- Care Coordination Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a Value-Based Program.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees
Federal law or state law may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

Nonparticipating Providers Outside the Claims Administrator's Service Area
- Your Liability Calculation. When Covered Services are provided outside of the Claims Administrator's service area, by nonparticipating Providers, the amount You pay for such services will normally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for nonparticipating emergency services.
- Exceptions. In certain situations, the Claims Administrator may use other payment methods, such as billed covered charges, the payment the Claims Administrator would make if the health care services had been obtained within the Claims Administrator's service area, or a special negotiated payment to determine the amount the Claims Administrator will pay for services provided by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

BLUE CROSS BLUE SHIELD GLOBAL CORE

If You are outside the United States (hereinafter "BlueCard service area"), You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard service area, You will typically have to pay the Providers and submit the claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, You should call the service center at 1 (800) 810-BLUE or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

- **Inpatient Services**
  In most cases, if You contact the service center for assistance, Hospitals will not require You to pay for covered inpatient services, except for Your applicable Deductible, Coinsurance, etc. In such

cases, the Hospital will submit Your claims to the service center to begin claims processing. However, if You paid in full at the time of services, You must submit a claim to receive reimbursement for Covered Services.

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require You to pay in full at the time of services. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When You pay for Covered Services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from the service center or online at **www.bcbsglobalcore.com**. If You need assistance with Your claim submission, You should call the service center at 1 (800) 810-BLUE or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

NONASSIGNMENT

Only You are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else and You (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity. Any attempted assignment, transfer or delegation of benefits will be considered null and void and will not be binding on the Plan. You may not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

CLAIMS RECOVERY

If a benefit to which You were not entitled is paid under the Plan, or if a person who is not eligible for benefits at all is paid under the Plan, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a Provider of services. The Plan's right to recovery for an erroneous payment made on the Participant's or any of his or her Beneficiary's behalf includes the right to deduct the mistakenly paid amount from future benefits that would have been provided the Participant or any of his or her Beneficiaries under this Plan.

The Claims Administrator regularly works to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). All recovered amounts will be credited to the Plan.

For the recovery of overpayments related to the coordination of Primary and Secondary Health Plan benefits, refer to the Coordination of Benefits provision in this Claims Administration Section.

This Claims Recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the other-party liability provision in the Claims Administration Section for additional information.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by the Claims Administrator. This information will be used for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law.

The information requested or disclosed may be related to treatment or services received from:

- an insurance carrier or group health plan;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies;
- a clinic, Hospital, long-term care or other medical facility; or
- a Physician, dentist, Pharmacist or other physical or behavioral health care Practitioner.

Health information requested or disclosed by the Claims Administrator may include, but is not limited to:

- billing statements;
- claim records;
- correspondence;
- dental records;
- diagnostic imaging reports;
- Hospital records (including nursing records and progress notes);
- laboratory reports; and
- medical records.

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by visiting the Claims Administrator's Web site or contacting Customer Service.

You have the right to request, inspect and amend any records that the Claims Administrator has that contain Your personal health information. Please contact the Claims Administrator's Customer Service department to make this request.

NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services and genetic testing. A specific authorization will be obtained from You in order for the Claims Administrator to receive information related to these health conditions.

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a health care Provider. Neither the Plan nor the Claims Administrator is responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since neither the Plan nor the Claims Administrator provides any health care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of the Plan or the Claims Administrator.

In addition, the Claims Administrator will not be liable to any person or entity for the inability or failure to procure or provide the benefits in the Plan by reason of epidemic, disaster or other cause or condition beyond the Claims Administrator's control.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Claimants who incur claims and are or have been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of Your estate, Your decedents, minors, and incompetent or disabled persons. No adult Claimant hereunder, may assign any rights that it may have to recover expenses from any tortfeasor or other person or entity to any minor child or children of said adult Claimant without the prior express written consent of the Plan.

The Plan's Right of Subrogation or reimbursement, as set forth below, extend to all insurance coverage available to You due to an Injury, Illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

This Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage, excess coverage or similar contract or insurance.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

Subrogation
The "Right of Subrogation" means the Plan is entitled to pursue any claims that You may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of Your rights of recovery with respect to any claim or potential claim against any party, due to an Injury, Illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement
If You receive any payment as a result of an Injury, Illness or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that Injury, Illness or condition, up to and including the full amount of Your recovery. Benefit payments made under the Plan are conditioned upon Your agreement to reimburse the Plan in full from any recovery You receive for Your Injury, Illness or condition.

Constructive Trust
By accepting benefits (whether the payment of such benefits is made to You or made on Your behalf to any Provider) You agree that if You receive any payment as a result of an Injury, Illness or condition, You will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of Your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights
Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the Illness, Injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any Illness, Injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, You, Your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment
In order to secure the Plan's recovery rights, You agree to assign to the Plan any benefits or claims or rights of recovery You have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have, whether or not You choose to pursue the claim.

First-Priority Claim
By accepting benefits from the Plan, You acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before You receive any recovery for Your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make You whole or to compensate You in part or in whole for the damages sustained. The Plan is not required to participate in or pay Your court costs or attorney fees to any attorney You hire to pursue Your damage claim.

Applicability to All Settlements and Judgments
The terms of this entire Subrogation and Right of Recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than expenses provided by the Plan. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to Your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is Your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Injury, Illness or condition. You and Your agents agree to provide the Plan or its representatives notice of any recovery You or Your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt of recovery funds. Further, You and Your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery You receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Your health benefits or the institution of court proceedings against You.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the Injury, Illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Workers' Compensation

If the entity providing workers' compensation coverage denies Your claim and You have filed an appeal, benefits may be advanced for Covered Services if You agree to hold any recovery obtained in a segregated account for the Plan.

Future Medical Expenses

Benefits for otherwise Covered Services may be excluded when You have received a recovery from another source relating to an Illness or Injury for which benefits would normally be provided. However, the amount of any Covered Services excluded under this provision will not exceed the amount of Your recovery.

Interpretation

In the event that any claim is made that any part of this Subrogation and Right of Recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator shall have the sole authority to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, You agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, You hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of Your present or future domicile. By accepting such benefits, You also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

COORDINATION OF BENEFITS

If You are covered under any other individual or group medical contract or policy (referred to as "Other Plan" and defined below), the benefits in this Plan and those of the Other Plan will be coordinated in accordance with the provisions of this section.

Benefits Subject to this Provision

All of the benefits provided in this Summary Plan Description are subject to this Coordination of Benefits provision.

Definitions
In addition to the definitions in the Definitions Section, the following are definitions that apply to this Coordination of Benefits Section:

Allowable Expense means, with regard to services that are covered in full or part by this Plan or any Other Plan(s) covering You, the amount on which that Plan would base its benefit payment for a service, including Coinsurance or Copayments and without reduction for any applicable Deductible, except that the following are examples of expenses that are not an Allowable Expense:

- An expense or portion of an expense not covered by any of Your involved Plans.
- Any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless one of Your involved Plans provides coverage for private Hospital rooms.
- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that Plan's provisions regarding second surgical opinion or preauthorization.
- If You are covered by two or more Plans that: 1) compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit; or 2) that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
- If You are covered by a Plan that calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, that negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

When a Plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

Birthday, for purposes of these Coordination of Benefits provisions, means only the day and month of birth, regardless of the year.

Custodial Parent means the legal Custodial Parent or the physical Custodial Parent as awarded by a court decree. In the absence of a court decree, Custodial Parent means the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

Group-Type Coverage is a coverage that is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including blanket coverage. Group-Type Coverage does not include an individually underwritten and issued guaranteed renewable coverage, even if the coverage is purchased through payroll deduction at a premium savings to You (since You would have the right to maintain or renew the coverage independently of continued employment with the employer).

Other Plan means any of the following with which this coverage coordinates benefits:

- Individual and group accident and health insurance and subscriber contracts.
- Uninsured arrangements of group or Group-Type Coverage.
- Group-Type Coverage.
- Coverage through closed panel Plans (a Plan that provides coverage primarily in the form of services through a panel of Providers that have contracted with or are employed by a Plan and that excludes benefits for services provided by other Providers, except in the cases of emergency or referral by a panel member).
- Medical care components of long-term care contracts, such as skilled nursing care.

- Medicare and other governmental coverages, as permitted by law.

Other Plan does not include:

- Hospital indemnity coverage benefits or other fixed indemnity coverage.
- Accident only coverage.
- Specified disease or specified accident coverage.
- Limited benefit health coverage.
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.
- Benefits provided in long-term care insurance policies for non-medical services (for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and Custodial Care) or for coverages that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
- Medicare supplement coverage.
- A state Plan under Medicaid, or a governmental Plan that, by law, provides benefits that are in excess to those of private insurance or other nongovernmental coverage.

Primary Plan means the Plan that must determine its benefits for Your health care before the benefits of another Plan and without taking the existence of that Other Plan into consideration. (This is also referred to as the Plan being "primary" to another Plan.) There may be more than one Primary Plan. A Plan is a Primary Plan with regard to another Plan in any of the following circumstances:

- The Plan has no order of benefit determination provision or its order of benefit determination provision differs from the order of benefit determination provision included herein; or
- Both Plans use the order of benefit determination provision included herein and under that provision the Plan determines its benefits first.

Secondary Plan means a Plan that is not a Primary Plan.

Year, for purposes of this Coordination of Benefits provision, means Calendar Year (January 1 through December 31).

Order of Benefit Determination

The order of benefit determination is identified by using the first of the following rules that applies:

Non-dependent or dependent coverage: A Plan that covers You other than as a dependent, for example as an employee, member, policyholder retiree, or subscriber, will be primary to a Plan under which You are covered as a dependent.

Child covered under more than one Plan: Plans that cover You as a child shall determine the order of benefits as follows:

- When Your parents are married or living together (whether or not they have ever been married), the Plan of the parent whose Birthday falls earlier in the Year is the Primary Plan. If both parents have the same Birthday, the Plan that has covered a parent longer is the Primary Plan.

- When Your parents are divorced or separated or are not living together (if they have never been married) and a court decree states that one of Your parents is responsible for Your health care expenses or health care coverage, the Plan of that parent is primary to the Plan of Your other parent. If the parent with that responsibility has no health care coverage for Your health care expenses, but that parent's spouse does, the Plan of the spouse shall be primary to the Plan of Your other parent.

- If a court decree states that both parents are responsible for Your health care expenses or health care coverage, or if a court decree states that the parents have joint custody of You, without specifying that one of the parents is responsible for Your health care expenses or health care coverage, the provisions of the first bullet above (based on parental Birthdays) shall determine the order of benefits.

- If there is no court decree allocating responsibility for Your health care expenses or health care coverage, the order of benefits is as follows:

  - The Plan of Your custodial parent shall be primary to the Plan of Your custodial parent's spouse;
  - The Plan of Your custodial parent's spouse shall be primary to the Plan of Your noncustodial parent; and
  - The Plan of Your noncustodial parent shall be primary to the Plan of Your noncustodial parent's spouse.

If You are covered under more than one Plan and one or more of the Plans provides You coverage through individuals who are not Your parents (for example, a guardian or step-parent), the order of benefits shall be determined, as applicable using the provisions under the first or second bullets above, as if those individuals were Your parents.

Active, retired, or laid-off employees: A Plan that covers You as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee, is primary to a Plan under which You are covered as a laid off or retired employee. If the Other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

COBRA or state continuation coverage: A Plan that covers You as an employee, member, subscriber or retiree or as a dependent of an employee, member, subscriber or retiree, is primary to a Plan under which You are covered pursuant to COBRA or a right of continuation pursuant to state or other federal law. If the Other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

Longer/shorter length of coverage: When none of the paragraphs above establishes an order of benefit determination, the benefits of the Plan that has covered You for the longer period of time will be determined before the benefits of the Plan that has covered You for the shorter period of time. To determine the length of time You have been covered under a Plan, two successive Plans will be treated as one if You were eligible under the second Plan within 24 hours after coverage under the first Plan ended. The start of a new Plan does not include:

- a change in the amount or scope of a Plan's benefits;
- a change in the entity that pays, provides or administers the Plan's benefits; or
- a change from one type of Plan to another (such as from a single-employer Plan to a multiple employer Plan).

Your length of time covered under a Plan is measured from Your first date of coverage under that Plan. If that date is not readily available for a group Plan, the date You first became a member of the group will be used as the date from which to determine the length of time coverage under the present Plan has been in force.

If an order of benefit determination is not identified by the preceding rules, the Plans shall share equally in the Allowable Expenses. Each of the Plans under which You are covered, and each of the benefits within the Plan, will be considered separately in administering this Coordination of Benefits provision.

Primary Health Plan Benefits

When, in accordance with the order of benefit determination, this coverage is the Primary Plan, benefits of this Plan will be paid as if no Other Plan exists. Despite the provisions of timely filing of claims, where this Plan is the Primary Plan, benefits will not be denied under this Plan on the ground that a claim was not timely submitted if the claim was timely submitted to one or more Secondary Plans and was submitted to the Claims Administrator within 36 months of the date of service.

Secondary Health Plan Benefits

If, in accordance with the order of benefit determination, one or more Other Plans are primary to this Plan, the benefits of this Plan will be calculated as follows:

The benefits that would have been paid under this Plan for a service if this Plan were the Primary Plan will be calculated. That calculated amount will be applied to any Allowable Expense under this Plan for that service that is unpaid by the Primary Plan. Regence will:

- reduce payment so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed 100 percent of the total Allowable Expense for that claim; and
- credit to this Plan's Deductible (if applicable), any amounts that would have been credited for the service if this Plan were the Primary Plan.

Nothing contained in this Coordination of Benefits provision requires this Plan to pay for all or part of any service that is not covered under this Plan. Further, in no event will this Coordination of Benefits provision operate to increase this Plan's payment over what would have been paid in the absence of this Coordination of Benefits provision.

Right to Receive and Release Needed Information

Certain facts are needed to apply Coordination of Benefits provisions. The Claims Administrator has the right to decide which facts they need. The Claims Administrator may get needed facts from, or give them to, any other organization or person as permitted by law, and need not tell or get the consent of any person to do this. You will promptly furnish to the Claims Administrator any information necessary or appropriate to administer this Coordination of Benefits provision. Receipt of such information by the Claims Administrator will be a condition precedent to this Plan's obligation to provide benefits.

Right of Recovery

If benefits under this Plan to or on behalf of You in excess of the amount that would have been payable in this Plan by reason of Your coverage under any Other Plan(s), this Plan will be entitled to the excess as follows:

- From You, if payment was made to You. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentations. This Plan will be entitled to recover the amount of such excess by the reversal of payment from You and You agree to reimburse this Plan on demand for any and all such amounts. You also agree to pay this Plan interest at 18 percent per annum until such debt is paid in full, which will begin accruing on excess amounts that remain outstanding 90 days after the date the demand for reimbursement is made. If a third-party collection agency or attorney is used to collect the overpayment, You agree to pay collection fees incurred, including, but not limited to, any court costs and attorney fees. If You do not pay, future benefits under this Plan may be withheld to offset the amount owing to it. The Claims Administrator is responsible for making proper adjustments between insurers and Providers.
- From Providers, if payment was made to them. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentation(s). The Claims Administrator is responsible for making proper adjustments between insurers and Providers.
- From the Other Plan or an insurer.
- From other organizations.

A Secondary Plan that provides benefits in the form of services may recover the reasonable cash value of the services from the Primary Plan to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by it.

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action under the Plan and wishes to have it reviewed, You may Appeal. There are two levels of Appeal, as well as additional voluntary Appeal levels You may pursue. Certain matters requiring quicker consideration qualify for a level of expedited Appeal and are described separately later in this section.

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Attn: Appeals, Regence BlueCross BlueShield of Utah, P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526. Verbal requests can be made by calling the Claims Administrator's Customer Service.

Each level of Appeal, except voluntary external review, must be pursued within 180 days of Your receipt of the Claims Administrator's determination (or, in the case of the first level, within 180 days of Your receipt of the Claims Administrator's original adverse decision that You are Appealing). You, or Your Representative on Your behalf, will be given a reasonable opportunity to provide written materials. If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum.

If Your health could be jeopardized by waiting for a decision under the regular Appeal process, an expedited Appeal may be requested. Please see Expedited Appeals later in this section for more information.

First-Level Appeals

First-level Appeals are reviewed by a Claims Administrator employee or employees who were not involved in the initial decision that You are Appealing. In Appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of health care professionals. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 15 days of receipt of the Appeal.

Second-Level Appeals

Second-level Appeals are reviewed by the Claims Administrator employee or employees who were not involved in, or subordinate to anyone involved in, the initial or the first-level decision. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 15 days of receipt of the Appeal.

VOLUNTARY EXTERNAL APPEAL - IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available for issues involving medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or the determination that a treatment is Investigational), but only after You have exhausted all of the applicable non-voluntary levels of Appeal, or if the Claims Administrator has failed to adhere to all claims and internal Appeal requirements. Voluntary External Appeals must be requested within four months of Your receipt of the notice of the prior adverse decision.

The Claims Administrator coordinates voluntary external Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. The IRO will make its decision and provide You with its written determination within 45 days after their receipt of the request. Choosing the voluntary external Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section, except to the extent other remedies are available under State or Federal law.

The voluntary external Appeal by an IRO is optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have under the Plan. This includes but is not limited to civil action under Section 502(a) of ERISA, where applicable.

EXPEDITED APPEALS

An expedited Appeal is available if one of the following applies:

- the application of regular Appeal time frames on a Pre-Service or concurrent care claim could jeopardize Your life, health or ability to regain maximum function; or
- according to a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

First-Level Expedited Appeal

The first-level expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. First-level expedited Appeals are reviewed by the Claims Administrator's staff of healthcare professionals who were not involved in, or subordinate to anyone involved in, the initial denial determination. A verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. A written notification of the decision will be mailed to You within three calendar days of the verbal notification.

Voluntary Expedited External Appeal - IRO

If You disagree with the decision made in the first-level expedited Appeal and You or Your Representative reasonably believes that preauthorization remains clinically urgent (Pre-Service or concurrent), You may request a voluntary expedited external Appeal to an IRO. The criteria for a voluntary expedited external Appeal to an IRO are the same as described above for voluntary external expedited Appeal.

The Claims Administrator coordinates voluntary expedited external Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. Verbal notice of the IRO's decision will be provided to You and Your Representative by the IRO as soon as possible after the decision, but no later than within 72 hours of its receipt of Your request, followed by written notification within 48 hours of the verbal notification. Choosing the voluntary expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section.

The voluntary expedited Appeal by an IRO is optional and You should know that other forums may be used as the final level of expedited Appeal to resolve a dispute You have under the Plan, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable.

INFORMATION

If You have any questions about the Appeal Process outlined here, You may call the Claims Administrator's Customer Service or You can write to the Claims Administrator's Customer Service department at the following address: Regence BlueCross BlueShield of Utah, P.O. Box 1827, MS CS B32B, Medford, OR 97501-9884 or facsimile 1 (877) 663-7526.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

Appeal means a written or verbal request from a Claimant or, if authorized by the Claimant, the Claimant's Representative, to change a previous decision made under the Plan concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between a Claimant and the Plan; and
- other matters as specifically required by state law or regulation.

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary external Appeals and voluntary expedited Appeals, through an independent contractor relationship with the Claims Administrator and/or through assignment to the

Claims Administrator via state regulatory requirements. The IRO is unbiased and is not controlled by the Claims Administrator.

Post-Service means any claim for benefits under the Plan that is not considered Pre-Service.

Pre-Service means any claim for benefits under the Plan which must be approved in advance, in whole or in part, in order for a benefit to be paid.

Representative means someone who represents You for the purpose of the Appeal. The Representative may be an attorney, Your authorized Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the purpose of the Appeal. No authorization is required from the parent(s) or legal guardian of a Claimant who is an unmarried and dependent child and is less than 13 years old. For expedited Appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for each Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to You or Your treating Provider only.

Who Is Eligible, How to Enroll and When Coverage Begins

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible, during a period of special enrollment or during an annual enrollment period. It also describes when coverage under the Plan begins for You and/or Your eligible dependents. Of course, payment of any corresponding monthly costs is required for coverage to begin on the indicated dates.

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of Your first becoming eligible for coverage under the eligibility requirements in effect with the Plan Sponsor and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

Except as described under the special enrollment provision, if You and/or Your eligible dependents do not enroll for coverage under the Plan when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual enrollment period to enroll.

Employees

You become eligible to enroll in coverage on the date You have worked for the Plan Sponsor long enough to satisfy the required 90 day probationary period.

Dependents

Your Beneficiaries are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when the Claims Administrator has enrolled them in coverage under the Plan. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your domestic partner, provided that all of the following conditions are met:
    - You have completed, executed and submitted an affidavit of qualifying domestic partnership form with regard to Your domestic partner;
    - both You and Your domestic partner are age 18 or older;
    - You and Your domestic partner share a close, personal relationship and are responsible for each other's common welfare;
    - neither You nor Your domestic partner is legally married to anyone else or has had another domestic partner within the 30 days immediately before enrollment of Your domestic partner;
    - You and Your domestic partner share the same regular and permanent residence and intend to continue doing so indefinitely;
    - You and Your domestic partner share joint financial responsibility for Your basic living expenses, including food, shelter and medical expenses; and
    - You and Your domestic partner are not more closely related by blood than would bar marriage in Your state of residence.
- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:
    - Your (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
    - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
    - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and who is a Disabled Dependent due to a Physical Impairment or a Mental Impairment that began before his or her 26th birthday, if You complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's impairment, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:

- he or she is a Beneficiary immediately before his or her 26th birthday; or
- his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on accident and health insurance since that birthday.

The Claims Administrator's affidavit of dependent eligibility form is available by visiting their Web site or by contacting Customer Service.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request (and, for a domestic partner, an affidavit of qualifying domestic partnership form) to the Claims Administrator. Request for enrollment of a new child by birth, adoption or placement for adoption must be made within 60 days of the date of birth, adoption or placement for adoption. Request for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates (which, for a new child by birth, adoption or placement for adoption, is the date of birth, adoption or placement for adoption, if enrolled within the specified 60 days).

NOTE: When the addition of a new child by birth, adoption or placement for adoption does not cause a change in Your payment under the Plan (as of the date of birth, date of adoption or date of placement for adoption), You will have 60 days as of the date the Claims Administrator first sends a denial of a claim for such new dependent to submit a signed group change request.

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual enrollment period.

Note that loss of eligibility does not include a loss because You failed to timely pay Your portion of the cost of coverage or when termination of coverage was because of fraud. It also doesn't include Your decision to terminate coverage, though it may include Your decision to take another action (for example, terminating employment) that results in a loss of eligibility.

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to enroll for coverage under the Plan within 30 days from the date of the qualifying event (except that where the qualifying event is involuntary loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP), You have 60 days from the date of the qualifying event to enroll):

- You and/or Your eligible dependents lose coverage under another group or individual health benefit plan due to one of the following:
  - an employer's contributions to that other plan are terminated;
  - exhaustion of federal COBRA or any state continuation; or
  - loss of eligibility, for instance, due to legal separation, divorce, termination of domestic partnership, death, termination of employment or reduction in hours.
- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than the Children's Health Insurance Program (CHIP), see below).
- You lose coverage under Medicaid or the Children's Health Insurance Program (CHIP).

For the above qualifying events, if enrollment is requested as specified, coverage will be effective on the day after the prior coverage ended.

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner, except as noted) and any eligible children are eligible to enroll for coverage under the Plan within 30 days from the date of the qualifying event:

- You marry or begin a domestic partnership;
- You acquire a new child by birth, adoption or placement for adoption. NOTE: Your domestic partner is not eligible to enroll for coverage under the Plan in this situation; or
- You become eligible for premium assistance under Title 26, Chapter 18 of the Medical Assistance Act (receipt of written notification of the eligibility for premium assistance is considered the date of the qualifying event).

If You are already enrolled or if You declined coverage when first eligible and subsequently have the following qualifying event, You (unless already enrolled), Your spouse (or Your domestic partner, except as noted) and any eligible children are eligible to enroll for coverage under the Plan within 60 days from the date of the qualifying event:

- You and/or Your dependent(s) become eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP).

For the above qualifying events, if enrollment is requested as specified, coverage will be effective on the first of the calendar month following the date of the qualifying event, except that where the qualifying event is a child's birth, adoption or placement for adoption, or You marry or begin a domestic partnership, coverage is effective from the date of the qualifying event.

ANNUAL ENROLLMENT PERIOD

The annual enrollment period is the only time, other than initial eligibility or a special enrollment period, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form (and, in the case of a domestic partner, a completed affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

TRANSFER DURING ANNUAL ENROLLMENT PERIOD

The annual enrollment period is the period of time during which You and/or Your eligible dependents may transfer directly to the Plan described in this Summary Plan Description from one of the Plan Sponsor's other health benefit plans. You must file an enrollment form (and, in the case of a domestic partner, a completed affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished any information necessary and appropriate to determine the eligibility of a dependent. Such information must be received before enrolling a person as a dependent under the Plan.

DEFINITIONS SPECIFIC TO THE WHO IS ELIGIBLE, HOW TO ENROLL AND WHEN COVERAGE BEGINS SECTION

Disabled Dependent means a child who is and continues to be: 1) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable Physical or Mental Impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and 2) dependent on You for more than 50 percent of their support (food, shelter, clothing, medical and dental care, education and the like).

Mental Impairment means a mental or psychological disorder such as: 1) intellectual disability; 2) organic brain syndrome; 3) emotional or mental illness or 4) specific learning disabilities as determined by the Claims Administrator.

Physical Impairment means a physiological disorder, condition or disfigurement, or anatomical loss affecting one or more of the following body systems: 1) neurological; 2) musculoskeletal; 3) special sense organs; 4) respiratory organs; 5) speech organs; 6) cardiovascular; 7) reproductive; 8) digestive; 9) genito-urinary; 10) hemic and lymphatic; 11) skin or 12) endocrine.

When Coverage Ends

This section describes the situations when coverage will end for You and/or Your Beneficiaries. You must notify the Claims Administrator within 30 days of the date on which an enrolled Beneficiary is no longer eligible for coverage.

No person will have a right to receive any benefits after the Plan terminates. Termination of Your or Your Beneficiary's coverage under the Plan for any reason will completely end all obligations to provide You or Your Beneficiary benefits for Covered Services received after the date of termination. This applies whether or not You or Your Beneficiary is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while the Plan was in effect.

AGREEMENT TERMINATION

If the Agreement is terminated or not renewed, claims administration by Regence ends for You and Your Beneficiaries on the date the Agreement is terminated or not renewed (except, if agreed between the Plan Sponsor and Regence, Regence may administer certain claims for services that Claimants received before that termination or nonrenewal).

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, Your and Your Beneficiaries' coverage ends on the date on which Your eligibility ends. However, it may be possible for You and/or Your Beneficiaries to continue coverage under the Plan according to the continuation of coverage provisions in this Summary Plan Description.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Plan, Your coverage will end for You and all Beneficiaries on the date on which employment ends.

NONPAYMENT

If You fail to make required timely contributions to the cost of coverage under the Plan, Your coverage will end for You and all Beneficiaries.

FAMILY AND MEDICAL LEAVE

If Your employer grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA") the following rules will apply. The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the FMLA:

- You and Your Beneficiaries will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
  - in order to care for Your newly born child;
  - in order to care for Your spouse, child or parent, if such spouse, child or parent has a serious health condition;
  - the placement of a child with You for adoption or foster care; or
  - You suffer a serious physical or Mental Health Condition.

During the FMLA leave, You must continue to make payments for coverage through the Plan Sponsor on time. The provisions described here will not be available if the Plan terminates.

If You and/or Your Beneficiaries elect not to remain enrolled during the FMLA leave, You (and/or Your Beneficiaries) will be eligible to be reenrolled under the Plan on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new enrollment form just as if You were a newly eligible employee. In this situation, if You reenroll within the required time, all of the terms and conditions of the Plan will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Beneficiaries) will receive credit for any waiting period served before the

FMLA leave and You will not have to re-serve any probationary period under the Plan, although You and/or Your Beneficiaries will receive no waiting period credits for the period of noncoverage.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purpose of COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Plan Sponsor must keep the Claims Administrator advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

LEAVE OF ABSENCE

If You are granted a non-FMLA temporary leave of absence by Your employer, You can continue coverage for up to three months. Payments must be made through the Plan Sponsor in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by Your employer at Your request during which You are still considered to be employed and are carried on the employment records of the Plan Sponsor. A leave can be granted for any reason acceptable to Your employer. If You are on leave for an FMLA-qualifying reason, You remain eligible under the Plan only for a period equivalent to FMLA leave and may not also continue coverage under a non-FMLA leave.

If You and/or Your Beneficiaries elect not to remain enrolled during the leave of absence, You (and/or Your Beneficiaries) may reenroll under the Plan only during the next annual enrollment period.

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the date in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the continuation of coverage provisions in this Summary Plan Description.

Divorce or Annulment

Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the date a divorce or annulment is final.

If You Die

If You die, coverage for Your Beneficiaries ends on the date on which Your death occurs.

Termination of Domestic Partnership

If Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the date of termination of the domestic partnership. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. You may not file another affidavit of qualifying domestic partnership within 90 days after a request for termination of a domestic partnership has been received.

Loss of Dependent Status

- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the monthly period in which the child exceeds the dependent age limit.

- For an enrolled child who is no longer eligible due to disruption of placement before legal adoption and who is removed from placement, eligibility ends on the last day of the monthly period in which the child is removed from placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the monthly period in which the child is no longer a dependent.

OTHER CAUSES OF TERMINATION

Claimants terminated for any of the following reasons may be able to continue coverage under the Plan according to the continuation of coverage provisions in this Summary Plan Description.

Strike or Other Labor Dispute

Coverage ends on the date you are no longer actively at work due to a strike or other labor dispute.

Fraudulent Use of Benefits

If You or Your Beneficiary engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under the Plan will terminate for that Claimant. The Claimant may reenroll 12 months after the date of discontinuance if the Plan Sponsor's coverage is in effect at the time the Claimant applies to reenroll.

Fraud or Misrepresentation in Application

Coverage under the Plan is based upon all information furnished to the Claims Administrator, for the benefit of the Plan by You or on behalf of You and Your Beneficiaries. In the event of any intentional misrepresentation of material fact or fraud, the Plan will have the following rights in accordance with Utah Code Annotated 31A-31-103 (or any successor thereto):

- With regard to a Claimant's health status, a retrospective adjustment to the cost of coverage under the Plan may be made as would have been appropriate if true, accurate or complete information had been provided at the time of enrollment.
- With regard to a Claimant (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Plan), coverage will be retroactively adjusted to the terms that would have existed if true, accurate or complete information had been received.

COBRA Continuation of Coverage

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups.

If the Plan is subject to COBRA, COBRA continuation is available to Your Beneficiaries if they lose eligibility because:

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce or the marriage is annulled;
- You and Your domestic partner terminate the domestic partnership;
- You become entitled to Medicare benefits; or
- Your Beneficiary loses eligibility as a child under this coverage.

COBRA also is available to You if You lose eligibility because Your employment terminates (other than for gross misconduct) or Your hours of work are reduced. (A special COBRA continuation also applies to You and Your Beneficiaries under certain conditions if You are retired and Your employer files for bankruptcy.)

There are some circumstances involving disability or the occurrence of a second one of these events that can result in extension of the limited period of continuation following a termination of employment or reduction in working hours. COBRA also can terminate earlier than the maximum periods.

General Rules

Generally, You or Your Beneficiaries are responsible for payment of the full cost for COBRA continuation, plus an administration fee, even if the Plan Sponsor contributes toward the cost of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Beneficiary's rights under COBRA, You or Your Beneficiaries must inform the Plan Sponsor in writing within 60 days of:

- Your divorce or annulment, termination of domestic partnership or a loss of eligibility of a child;
- Your initial loss of eligibility due to Your termination of employment or reduction in working hours and You experience another one of the events listed above; or
- a Social Security disability determination that You or Your Beneficiary was disabled for Social Security purposes at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that You or Your Beneficiary is no longer disabled for Social Security purposes, You or Your Beneficiary must provide the Plan Sponsor notice of that determination within 30 days of the date it is made.)

The Plan Sponsor also must meet certain notification, election and payment deadline requirements. It is therefore very important that You keep the Plan Sponsor informed of the current address of all Claimants who are or may become qualified beneficiaries.

If You or Your Beneficiaries do not elect COBRA continuation coverage, coverage under the Plan will end according to the terms of the Agreement and claims under the Plan for services provided on and after the date coverage ends will not be paid. Further, this may jeopardize Your or Your Beneficiaries' future eligibility for an individual plan.

Notice

The complete details on the COBRA Continuation provisions outlined here are available from the Plan Sponsor.

General Provisions

This section explains various general provisions regarding Your benefits under this coverage.

CHOICE OF FORUM

Any legal action arising out of the Plan benefit option described herein must be filed in a court in the state of Utah.

GOVERNING LAW AND DISCRETIONARY LANGUAGE

The Plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Utah without regard to its conflict of law rules. The Plan Administrator, the Plan Sponsor, delegates the Claims Administrator discretion for the purpose of paying benefits under this coverage only if it is determined that You are entitled to them and of interpreting the terms and conditions of the plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations in federal court. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when You seek judicial review of a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the Plan. The Claims Administrator is not the Plan Administrator, but does provide claims administration under the Plan, and the court will determine the level of discretion that it will accord the Claims Administrator's determinations.

PLAN SPONSOR IS AGENT

The Plan Sponsor is Your agent for all purposes under the Plan and not the agent of Regence BlueCross BlueShield of Utah. You are entitled to health care benefits pursuant to the Plan. In the Agreement, the Plan Sponsor agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in this Summary Plan Description. You, through the enrollment form signed by the Participant, and as beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Summary Plan Description.

NO WAIVER

The failure or refusal of either party to demand strict performance of the Plan or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the Plan will be considered waived unless such waiver is reduced to writing and signed by one of the Plan Sponsor's authorized officers.

NOTICES

Any notice to Claimants or to the Plan Sponsor required in the Plan will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant or to the Plan Sponsor will be addressed to the Participant or to the Plan Sponsor at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address form (COA) for a Participant, it will update its records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Administrator or Plan Sponsor if it becomes aware that it doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be given by mail addressed to: Regence BlueCross BlueShield of Utah, P.O. Box 2998, Tacoma, WA 98401-2998; provided, however that any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Plan Sponsor on behalf of itself and its Claimants expressly acknowledges its understanding that the Agreement constitutes an agreement solely between the Plan Sponsor and Regence, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting Regence to use the Blue Cross and Blue Shield Service Marks in the state of Utah and that Regence is not contracting as the agent of the Association. The Plan Sponsor on behalf of itself and its Claimants further acknowledges and agrees that it has not entered into the Agreement based upon representations by any

person or entity other than Regence and that no person or entity other than Regence will be held accountable or liable to the Plan Sponsor or the Claimants for any of Regence's obligations to the Plan Sponsor or the Claimants created under the Agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence other than those obligations created under other provisions of the Agreement.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an enrollment form will be considered representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered in this Plan, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

- the person is eligible to be covered according to the eligibility provisions described in the Plan Document; and
- the person has enrolled in coverage and has been enrolled by the Claims Administrator.

The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You.

WOMEN'S HEALTH AND CANCER RIGHTS

If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, coverage under the Plan will be provided (subject to the same provisions as any other benefit) for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Definitions

The following are definitions of important terms used in this Summary Plan Description. Other terms are defined where they are first used.

Affiliate means a company with which the Claims Administrator has a relationship that allows access to Providers in the state in which the Affiliate serves and includes the following companies: Regence BlueShield of Idaho in the state of Idaho, Regence BlueCross BlueShield of Oregon in the state of Oregon and Regence BlueShield in parts of the state of Washington.

Allowed Amount means:

- For In-Network Providers (see definition of "In-Network" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network" below) who are not accessed through the BlueCard Program, the amount the Claims Administrator has determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.
- For Out-of-Network Providers accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that Provider. In exceptional circumstances, such as if the Host Blue does not identify an amount on which it would base payment, the Claims Administrator may substitute another payment basis.

Charges in excess of the Allowed Amount are not considered reasonable charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, please contact the Claims Administrator.

Ambulatory Surgical Center means a facility or that portion of a facility licensed by the state in which it is located, that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission. An Ambulatory Surgical Center must be a freestanding facility, meaning that it exists independently or is physically separated from another health care facility by fire walls and doors and is administered by separate staff with separate records.

Beneficiary means a Participant's eligible dependent who is listed on the Participant's completed enrollment form and who is enrolled under the Plan.

Calendar Year means the period from January 1 through December 31 of the same year; however, the first Calendar Year begins on the Claimant's Effective Date.

Claimant means a Participant or a Beneficiary.

Commercial Seller includes, but is not limited to, retailers, wholesalers or commercial vendors that are not Providers, who are approved to provide medical supplies, equipment and devices in accordance with the provisions of this coverage.

Covered Service means a service, supply, treatment or accommodation that is listed in the benefits sections in this Summary Plan Description.

Custodial Care means care that is for the purpose of watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily for the purpose of separating the patient from others or preventing self-harm.

Dental Services means services or supplies (including medications) provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Effective Date means the date Your coverage under the Agreement begins after acceptance for enrollment under the Plan.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

- placing the Claimant's health, or with respect to a pregnant Claimant, her health or the health of her unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Family means a Participant and his or her Beneficiaries.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: disease, Illness, Injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

Health Outcome means an outcome that affects health status as measured by the length or quality of a person's life. The Health Intervention's overall beneficial effects on health must outweigh the overall harmful effects on health.

Hospital means a facility that is licensed as a general acute or specialty Hospital by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A Hospital has an attending medical staff consisting of one or more Physicians. A Hospital under this definition is not, other than incidentally, a place for rest, a nursing home or a facility for convalescence.

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder (which is otherwise defined in this Summary Plan Description).

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

In-Network means a Provider that has an effective participating contract with the Claims Administrator that designates him, her or it as a network Provider, who is a member of the Plan Sponsor's chosen Provider network, to provide services and supplies to Claimants in accordance with the provisions of this coverage. In-Network also means a Provider that has an effective participating contract with one of the Claims Administrator's Affiliates or a Provider outside the area that the Claims Administrator or one of its Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as an "In-Network" Provider) to provide services and supplies to Claimants in accordance with the provisions of this coverage. If the Claims Administrator or one of its Affiliates have more than one Provider network from which the Plan Sponsor may choose for benefits under the Plan, then the Providers contracted under the network selected by the Plan Sponsor will be considered the only In-Network Providers for the purpose of payment of benefits in this Summary Plan Description. For In-Network reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

Investigational means a Health Intervention that the Claims Administrator has classified as Investigational. The Claims Administrator will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Investigational. A Health

Intervention not meeting all of the following criteria is, in the Claims Administrator's judgment, Investigational:

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Lifetime means the entire length of time a Claimant is covered under the Plan (which may include more than one coverage) through the Plan Sponsor with the Claims Administrator.

Medically Necessary or Medical Necessity means health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an Illness or Injury or its symptoms in a manner that is:

- in accordance with generally accepted standards of medical practice in the United States;
- clinically appropriate in terms of type, frequency, extent, site, and duration;
- not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease; and
- covered under the Plan.

When a medical question-of-fact exists, Medical Necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and that is known to be effective. For Health Interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established Health Interventions, the effectiveness shall be based on first Scientific Evidence; then professional standards; and then expert opinion.

A HEALTH INTERVENTION MAY BE MEDICALLY INDICATED OR OTHERWISE BE MEDICALLY NECESSARY, YET NOT BE A COVERED SERVICE UNDER THE PLAN.

Out-of-Network refers to Providers that are not In-Network. For reimbursement of these Out-of-Network Provider services, You may be billed for balances over Plan payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services provided inside or outside the area that the Claims Administrator or one of its Affiliates serves.

Participant means an employee of the Plan Sponsor who is eligible under the terms described in this Summary Plan Description, has completed an enrollment form and is enrolled under this coverage.

Physician means an individual who is duly licensed to practice medicine and surgery in all of its branches or to practice as an osteopathic Physician and surgeon.

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include podiatrists, chiropractors, psychologists, certified nurse midwives, certified registered nurse anesthetists, dentists and other professionals practicing within the scope of his or her respective licenses.

Primary Physician or Practitioner means a Physician, osteopathic Physician or Practitioner that is licensed in general or family practice, internal medicine, pediatrics, geriatrics, obstetrics/gynecology (Ob/Gyn), preventive medicine, adult medicine or women's health care who, when acting within the scope of their state license, provides Your primary care or coordinates referral services when needed. Primary Physician or Practitioner also means any nurse Practitioner or advanced registered nurse Practitioner licensed in one of the above specialties and working under a Physician, osteopathic Physician or Practitioner who is licensed in the same specialty.

Provider means a Hospital, Skilled Nursing Facility, Ambulatory Surgical Center, Physician, Practitioner or other individual or organization which is duly licensed to provide medical or surgical services.

Regence refers to Regence BlueCross BlueShield of Utah.

Rehabilitation Facility means a facility or distinct part of a facility that is licensed as a Rehabilitation Facility by the state in which it is located and that provides an intensive, multidisciplinary approach to rehabilitation services under the direction and supervision of a Physician.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Skilled Nursing Facility means a facility or distinct part of a facility which is licensed by the state in which it is located as a nursing care facility and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

Specialist means a Physician, Practitioner or urgent care facility that does not otherwise meet the definition of a Primary Physician or Practitioner.

Summary Plan Description (SPD) is a summary of the benefits provided by the Group Health Plan (GHP). A GHP with different benefit plan options may describe them in one SPD or in separate SPDs for each alternative benefit plan option.

Upfront Benefit means those Covered Services designated as "Upfront" which are usually accessible to the Claimant without first having to satisfy any Deductible amount. Generally, there will also be no Coinsurance amount required for an Upfront Benefit, however, a Copayment or Coinsurance may still apply for each visit or access to an Upfront Benefit. Once an Upfront Benefit dollar or visit maximum (if applicable) has been reached, additional coverage is available subject to a Deductible, Copayment and/or Coinsurance. Refer to the Upfront Benefit provisions in the Medical Benefits Section to determine coverage.

Summary Plan Description

The Plan is an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA). For further information regarding ERISA, contact the Plan Sponsor. Note that the terms "You" and "Your" in this Summary Plan Description Section by and large refer to the Participant.

PLAN NAME
Swire Pacific Holdings

NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR
Swire Pacific Holdings Inc., dba Swire Coca-Cola USA
12634 South 265 West
Draper, UT 84020
(801) 816-5300

EMPLOYER IDENTIFICATION NUMBER ASSIGNED FOR THIS PLAN BY THE IRS
87-0424812

PLAN NUMBER
60021265

TYPE OF PLAN
Welfare Benefit Plan: medical and prescription medication benefits.

TYPE OF ADMINISTRATION
The processing of claims for benefits under the terms of the Plan are provided through a company contracted by the Plan Sponsor which hereinafter is referred to as the Claims Administrator.

NAME, ADDRESS AND PHONE NUMBER OF PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS
Swire Pacific Holdings Inc., dba Swire Coca-Cola USA
12634 South 265 West
Draper, UT 84020
(801) 816-5300

Legal process may also be served upon the Plan Sponsor's address above.

SOURCES OF CONTRIBUTIONS TO THE PLAN
Contributions for plan expenses are obtained from Plan Sponsor and Participants.

FUNDING MEDIUM
Plan Sponsor will maintain an account for the receipt of money and property to fund the Plan, for the management and investment of such funds, and for the payment of Plan benefits and expenses from such funds.

All funds and earnings received by the Plan Sponsor will be applied toward payment of Plan benefits and reasonable expenses of administration of the Plan except to the extent otherwise provided by the Plan documents. The Plan Sponsor may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan.

Any fiduciary, employee, agent representative or other person performing services to or for the Plan shall be entitled to reasonable compensation for services rendered and for the reimbursement of expenses properly and actually incurred, unless such person already receives full-time pay from Plan Sponsor.

Enrollees shall look only to the Plan Sponsor's funds for payment of Plan benefits and expenses.

PLAN FISCAL YEAR ENDS ON
December 31

PLAN TERMINATION PROVISIONS

The Plan Sponsor expects and intends to continue the Plan indefinitely, but reserves its right to end the Plan at any time in its sole discretion. The Plan Sponsor also reserves the right to amend the Plan at any time in its sole discretion.

The Plan Sponsor's decision to end or amend the Plan may be due to changes in federal or state laws governing welfare benefits, the requirements of the IRS or ERISA, or for any other reason. A Plan change may transfer assets and liabilities to another plan or split this plan into two or more parts. If the Plan Sponsor does change or end the Plan, it may decide to set up a different plan providing similar or identical benefits.

If the Plan is terminated, plan participants and beneficiaries will not have any further rights. The amount and form of any final benefit will depend on any contract provisions affecting the Plan, and the Plan Sponsor's decisions.

NOTICE OF ERISA RIGHTS

As a participant under the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Receive a summary of the Plan's annual financial report. The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

Continue Employer Health Plan Coverage

Continue health care coverage for Yourself, spouse or children if there is a loss of coverage under the Plan as a result of a qualifying event under COBRA. You or Your Beneficiaries may have to pay for such coverage. Review this Plan Document and the documents governing the Plan for a description of the rules governing Your COBRA continuation coverage rights.

You should be provided a certificate of creditable coverage, free of charge, from Your group health plan when You lose coverage under the Plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

No one, including the Plan Sponsor or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a health and welfare benefit under the Plan or exercising Your rights under ERISA. If Your claim for a health and welfare benefit is denied in whole or in part, You must receive a written explanation of the reasons for the denial. You have the right to have the Plan Sponsor review and reconsider Your claim. Under ERISA, there are steps You can take to enforce these rights. For instance, if You request materials from the Plan and You do not receive them within 30 days, You may file suit in the Federal court. In such case, the court may require the Plan Administrator to

provide the material and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

Procedures For Filing Claims

If You have a claim for benefits (for Yourself or for one of Your Beneficiaries) which is denied or ignored in whole or in part, You have the right to a hearing before the Plan Sponsor at which You may present Your position and any supporting evidence. You also have the right to be represented by an attorney or any other representative of Your choice. Further, if You are dissatisfied with the Plan Sponsor's determination, You may pursue an action pursuant to 29 USC§1132(a).

For detailed information on how to submit a claim for benefits or how to file an appeal on a processed claim, refer to the Submission of Claims and Reimbursement and Appeals provisions in this Summary Plan Description.

In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that the plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the US Department of Labor, or You may file suit in Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance With Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA You should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue NW, Washington DC 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SUMMARY PLAN DESCRIPTION FOR:

Swire Pacific Holdings, Inc.

Group Number: 60021265

Vision Plan

Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Utah

Introduction

NOTE: THIS SUMMARY PLAN DESCRIPTION PROVIDES VISION BENEFITS ONLY. PLEASE REVIEW YOUR SUMMARY PLAN DESCRIPTION CAREFULLY.

Welcome to participation in the self-funded group vision plan (hereafter referred to as "Plan") provided for You by Your employer. Your employer has chosen Regence BlueCross BlueShield of Utah to administer claims for Your group vision plan. Throughout this Summary Plan Description, Your employer may be referred to as the "Plan Sponsor."

EMPLOYER PAID BENEFITS

Your Plan is an employer-paid benefits plan administered by Regence BlueCross BlueShield of Utah (usually referred to as the "Claims Administrator" in this Summary Plan Description). This means that Your employer, not Regence BlueCross BlueShield of Utah, pays for Your covered vision services and supplies. Your claims will be paid only after Your employer provides Regence BlueCross BlueShield of Utah with the funds to pay Your benefits and pay all other charges due under the Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Because of their extensive experience and reputation of service, Regence BlueCross BlueShield of Utah has been chosen as the Claims Administrator of Your Plan. As Claims Administrator, Regence BlueCross BlueShield of Utah has selected Vision Service Plan (VSP) to coordinate the provision of benefits and claims processing.

The following pages are the Summary Plan Description, the written description of the terms and benefits of coverage available under the Plan. This Summary Plan Description describes benefits effective **January 1, 2018**, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any plan description, Summary Plan Description or certificate previously issued by Regence BlueCross BlueShield of Utah and makes it void.

As You read this Summary Plan Description, please keep in mind that references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Who Is Eligible, How To Enroll and When Coverage Begins, When Coverage Ends and COBRA Continuation sections, the terms "You" and "Your" mean the Participant only). (NOTE: Where a reference is made to spouse, all of the same terms and conditions of the Summary Plan Description will be applied to a domestic partner, except when specified to the contrary.) The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used and are designated by the first letter being capitalized.

This employee benefit plan may be governed by the Employee Retirement Income Security Act (ERISA). Throughout the Summary Plan Description, references to "ERISA" will apply only if the Plan is part of an employee welfare benefit plan regulated under ERISA.

Notice of Privacy Practices: Regence BlueCross BlueShield of Utah has a Notice of Privacy Practices that is available by calling Customer Service or visiting the Web site listed below.

CONTACT INFORMATION

If You have Provider or benefit questions specific to Your vision coverage, call VSP at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday-Friday 5 a.m. - 8 p.m.; Saturday 7 a.m. - 8 p.m.; and Sunday 7 a.m. - 7 p.m. You may also visit VSP's Web site at **www.vsp.com**.

If You have membership questions, would like to learn more about Your coverage or would like to request written or electronic information regarding any other plan that the Claims Administrator offers, talk with one of the Claims Administrator's Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. Pacific Time.

Customer Service: 1 (866) 240-9580
(TTY: 711)

Or visit the Claims Administrator's Web site at: **regence.com**

For assistance in a language other than English please call the Customer Service telephone number.

Using Your Summary Plan Description

YOUR PARTNER IN VISION CARE

This Plan, provides You with great benefits that are quickly accessible and easy to understand, thanks to open access to Providers and innovative tools. With this vision care coverage, You will discover the personal freedom to make informed vision care decisions, as well as the assistance You need to navigate the vision care system.

ACCESSING PROVIDERS

Your Plan allows You to control Your out-of-pocket expenses, such as Copayments and/or Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your vision Provider under two choices called: "VSP Doctor" or "Out-of-Network Provider."

- **VSP Doctor.** You choose to see a VSP Doctor and save the most in Your out-of-pocket expenses. Choosing this vision provider option means You will not be billed for balances beyond the Allowed Amount.
- **Out-of-Network Provider.** You choose to see an Out-of-Network Provider who does not have a contract with VSP to provide services on behalf of Claimants under this Plan and Your out-of-pocket expenses will generally be higher than seeing a VSP Doctor. Also, choosing this vision provider option means You may be billed for balances beyond the Allowed Amount. This is sometimes referred to as balance billing.

For each vision benefit in this Summary Plan Description, the Provider You may choose and Your payment amount for each vision Provider option is indicated. VSP Doctor and Out-of-Network Provider are also in the Definitions Section of this Summary Plan Description. You can go to **www.vsp.com** for further vision Provider network information.

ADDITIONAL PARTICIPATION ADVANTAGES

Your Plan offers You access to valuable services. The advantages of Regence involvement as the Claims Administrator include access to discounts on select items and services, personalized health/vision care planning information, as well as a team dedicated to Your personal vision care needs. You also have access to **regence.com**, an interactive environment that can help You navigate Your way through treatment decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE GROUP VISION PLAN, BUT ARE NOT INSURANCE.**

- **Go to regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health/vision care shopper and increase the value of Your vision care dollar. Have Your Plan identification card handy to log on. Use the secure Web site to:

  - participate in online wellness programs and use tools to estimate upcoming healthcare costs; and
  - discover discounts on select items and services*.

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this Plan, that also may create savings for the Claims Administrator. **ANY SUCH DISCOUNTS OR COUPONS ARE COMPLEMENTS TO THE GROUP VISION PLAN, BUT ARE NOT INSURANCE.**

Table of Contents

Understanding Your Benefits

In this section, You will discover information to help You understand what is meant by Your Maximum Benefits, Copayments and Coinsurance. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used and are designated by the first letter being capitalized.

While this Understanding Your Benefits Section defines these types of cost-sharing elements, You need to refer to the Vision Benefits Section to see exactly how they are applied and to which benefits they apply.

MAXIMUM BENEFITS

Vision benefits for Covered Services may have a specific Maximum Benefit. For those Covered Services, benefits will be provided until the specified Maximum Benefit (which may be a number of visits, services, supplies, dollar amount or a specified time period) has been reached. Allowed Amounts for Covered Services provided are applied against any specific Maximum Benefit that is expressed in this Summary Plan Description. Refer to the Vision Benefits Section in this Summary Plan Description to determine if a Covered Service has a specific Maximum Benefit.

COPAYMENTS

Copayments are the fixed dollar amount that You must pay directly to the Provider for services or supplies each time You receive a specified service (as applicable). A Provider may or may not request any applicable Copayment at the time of service. The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service. Refer to the Vision Benefits Section to understand what Copayments (if any) You may be responsible for.

PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)

Once You have satisfied any applicable Copayment, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount. The percentage the Plan pays varies, depending on the kind of service or supply You received and who rendered it.

The Plan does not reimburse Providers for charges above the Allowed Amount. A VSP Doctor will not charge You for any balances for Covered Services beyond any applicable Copayment and/or Coinsurance amount. Out-of-Network Providers, however, may bill You for any balances over the Plan payment level in addition to the Copayment and/or Coinsurance amount. See the Definitions Section for descriptions of VSP Doctor and Out-of-Network Providers.

HOW CALENDAR YEAR BENEFITS RENEW

Many provisions in this Plan (for example, certain benefit maximums) are calculated on a Calendar Year basis, except as otherwise noted. Each January 1, those Calendar Year maximums begin again.

Vision Benefits

In this section, You will learn how Your vision coverage works. The explanation includes information about Maximum Benefits, Covered Services, specific limitations and payment. Covered Services are those Medically Necessary services required for the diagnosis or correction of visual acuity and must be rendered by a Physician or optometrist practicing within the scope of his or her license.

All terms and conditions in this Summary Plan Description apply to this Vision Benefits Section, except as otherwise noted. Please see the Definitions Section in the back of this Summary Plan Description for descriptions of the kinds of Providers who deliver Covered Services.

VISION EXAMINATION

Provider: VSP Doctor	**Provider: Out-of-Network**
Payment: After $20 Copayment, the Plan pays 100% of the Allowed Amount.	**Payment:** After $20 Copayment, the Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Frequency Period: one examination every Calendar Year	
Limit: $30 for Out-of-Network Provider	

The Plan covers professional complete medical eye examination or visual analysis, including:

- prescribing and ordering proper lenses;
- assisting in the selection of frames;
- verifying the accuracy of the finished lenses;
- proper fitting and adjustment of frames;
- subsequent adjustments to frames to maintain comfort and efficiency; and
- progress or follow-up work as necessary.

VISION HARDWARE

Provider: VSP Doctor	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Frame Frequency Period: one set of frames every Calendar Year	
Lens Frequency Period: one pair of lenses every Calendar Year	
Frame limit: $130 for VSP Doctor; $70 for VSP approved wholesale/retail vendor; $30 for Out-of-Network Provider	
Lens limit: VSP Doctor: • $130 elective contacts* Out-of-Network Provider: • $20 single vision • $30 lined bifocal or standard progressive lenses • $40 lined trifocal • $60 lenticular • $100 elective contacts* • $200 Necessary Contact Lenses* *Contact lenses are in lieu of all other frame and lens benefits. When You receive contact lenses, You will not be eligible for any frames and/or lenses until the next Calendar Year.	

The Plan covers frames and lenses, including:

- glass or plastic single vision lenses, lined bifocal lenses, standard progressive lenses or lined trifocal lenses;
- elective contact lenses; and
- Necessary Contact Lenses.

CONTACT LENS EVALUATION AND FITTING EXAMINATION

Provider: VSP Doctor	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Frequency Period: one contact lens evaluation and fitting examination every Calendar Year	
Limit: $100 combined with elective contacts for Out-of-Network Provider	

The Plan covers services and supplies for contact lens evaluation and fitting examinations.

LOW VISION BENEFIT

Supplemental Testing

Provider: VSP Doctor	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Frequency Period: every two Calendar Years	
Limit: $1,000 for VSP Doctor, combined with Supplemental Care Aids; $125 for Out-of-Network Provider	

The Plan covers complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplemental Care Aids

Provider: VSP Doctor	Provider: Out-of-Network
Payment: The Plan pays 75% and You pay 25% of the Allowed Amount.	**Payment:** The Plan pays 75% of the Allowed Amount and You pay balance of billed charges.
Frequency Period: every two Calendar Years	
Limit: $1,000 combined with Supplemental Testing.	

In addition to the benefits described above, the Plan covers special aid for people who have severe visual problems that cannot be corrected with regular lenses. If You fall within this category (check with Your Provider), You will be entitled to professional services as well as ophthalmic materials, including, but not limited to, supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and benefit limitations of these vision benefits. Consult Your VSP Doctor for more details.

LIMITATIONS

These Vision benefits are designed to cover visual needs rather than cosmetic materials. If You select any of the following extras, the Plan will pay the basic cost of the allowed lenses, and You will pay any additional costs for the following options:

- optional cosmetic processes;
- anti-reflective coating;
- color coating;
- mirror coating;
- scratch coating;
- blended lenses;
- cosmetic lenses;
- laminated lenses;
- oversize lenses;
- standard progressive lenses;
- premium and custom progressive multifocal lenses;
- photochromic lenses; tinted lenses except Pink #1 and Pink #2;
- UV (ultraviolet) protected lenses;
- certain limitations on low vision care;
- a frame that costs more than the limit in this Summary Plan Description; or
- contact lenses (not previously described as covered).

ADDITIONAL DISCOUNTS

You are entitled to receive a 20 percent discount toward the purchase of non-covered materials from any VSP Doctor when a complete pair of glasses is dispensed. You are also entitled to receive a 15 percent discount off of contact lens examination services from any VSP Doctor, beyond the covered exam.

Professional judgment will be applied when evaluating prescriptions written by an Out-of-Network Provider. VSP Doctors may request an additional exam at a discount.

Discounts are applied to the VSP Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye examination. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS VISION PLAN, BUT ARE NOT INSURANCE.**

Limitations

- Discounts do not apply to vision care benefits obtained from Out-of-Network Providers.
- 20 percent discount applies only when a complete pair of glasses is dispensed.
- Discounts do not apply to sundry items, for example, contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

General Exclusions

The following are the general exclusions from coverage in this Summary Plan Description. Other exclusions may apply and, if so, will be described elsewhere in this Summary Plan Description.

SPECIFIC EXCLUSIONS

The following are the general exclusions from coverage under the Plan. Other exclusions may apply and, if so, will be described elsewhere in this Summary Plan Description. Benefits under the Plan will not be provided for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law.

Certain Contact Lens Expenses

- artistically-painted or non-prescription contact lenses;
- contact lens modification, polishing or cleaning;
- refitting of contact lenses after the initial (90-day) fitting period;
- additional office visits associated with contact lens pathology; and
- contact lens insurance policies or service agreements.

Conditions Caused By Active Participation In a War or Insurrection

The treatment of any condition caused by or arising out of a Claimant's active participation in a war or insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Corneal Refractive Therapy (CRT)

Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia) or reversals or revisions of surgical procedures which alter the refractive character of the eye.

Corrective Vision Treatment of an Experimental Nature

Cosmetic Services and Supplies

Services and supplies for beautification, cosmetic or aesthetic purposes.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

Expenses Before Coverage Begins or After Coverage Ends

Services and supplies incurred before Your Effective Date under the Plan or after Your termination under the Plan.

Facility Charges

Services and supplies provided in connection with facility services.

Fees, Taxes, Interest

Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. The Plan also does not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Government Programs

Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with the Claims Administrator and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid.

Expenses from government facilities outside the service area are not covered under the Plan (except as required by law for emergency services).

Investigational Services
Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section in this Summary Plan Description.

Medical or Surgical Treatment of the Eyes
Medical or surgical treatment of the eyes, including reversals or revisions of surgical procedures of the eye.

Motor Vehicle Coverage and Other Available Insurance
Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to this Summary Plan Description.

Non-Direct Patient Care
Services that are not direct patient care, including:

- appointments scheduled and not kept (missed appointments);
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at the Claims Administrator's request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Orthoptics or Vision Training
Orthoptics or vision training and any associated supplemental testing.

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, contentment, personal hygiene, aesthetics or other nontherapeutic purposes.

Plano Lenses (Less than a ± .50 Diopter Power)

Replacement of Lenses and Frames
Except at the normal intervals when services are otherwise available, the Plan does not cover replacement of lenses and frames furnished under this Plan which are lost or broken.

Riot, Rebellion and Illegal Acts
Services and supplies for treatment of an Illness, Injury or condition caused by a Claimant's **voluntary participation in** a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Claimant arising directly from an act deemed illegal by an officer or a court of law.

Self-Help, Self-Care, Training or Instructional Programs
Self-help, non-vision self-care and training programs. This exclusion does not apply to services for training or educating a Claimant when provided without separate charge in connection with Covered Services.

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners siblings and half-siblings;
- Your child's or stepchild's spouse or domestic partner; and
- any other of Your relatives by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary
Services and supplies that are not Medically Necessary for the treatment of the diagnosis or correction of visual acuity.

Third-Party Liability
Services and supplies for treatment of Illness or Injury for which a third-party is or may be responsible.

Travel and Transportation Expenses
Travel and transportation expenses.

Two Pair of Glasses in Lieu of Bifocals

Work-Related Conditions
Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. The Claims Administrator may require the Claimant to file a claim for workers' compensation benefits before providing any benefits under this coverage. The Plan does not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if a Claimant is exempt from state or federal workers' compensation law. This exclusion shall also apply if You or Your Beneficiaries opt out of workers' compensation.

Claims Administration

This section explains a variety of matters related to administering benefits and/or claims, including situations that may arise when Your vision care expenses are the responsibility of a source other than the Plan.

PLAN IDENTIFICATION CARD

When Participants enroll in the Plan, they will receive Plan identification cards. The identification card will include important information such as the Participant's identification number, group number and name.

It is important to keep Your Plan identification card with You at all times. Be sure to present it to Your Provider before receiving care.

If You lose Your card, or if it gets destroyed, You can get a new one by contacting the Claims Administrator's Customer Service. You can also view or print an image of Your Plan identification card by visiting the Claims Administrator's Web site on Your PC or mobile device. If the Agreement terminates, Your Plan identification card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When You visit a VSP Doctor, the VSP Doctor will submit the claim directly to VSP for payment. If You visit an Out-of-Network Provider, however, You will need to pay the Provider his or her full fee at the time You receive the service or supply. You will need to submit a claim to VSP for reimbursement according to the benefits in this Plan, less any Copayment and/or Coinsurance. THERE IS NO ASSURANCE THAT PAYMENT WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR HARDWARE. Be sure the claim is complete and includes the following information:

- copy of claim receipt from the Provider, including Provider's name, address, date of service, and services performed. You may access Out-of-Network Reimbursement under My Benefits on VSP's Web site, **www.vsp.com**, to get a claim form to assist in submission of Out-of-Network Provider claims;
- Your name, date of birth, address and Claimant ID number; and
- patient's name, date of birth and relation to You.

Send to:

Vision Service Plan
P.O. Box 385020
Birmingham, AL 35238-5020

Calendar Year and Plan Year

Maximum Benefit provisions are calculated on a Calendar Year basis. The Agreement is renewed, with or without changes, each Plan Year. A Plan Year is the 12-month period following either the Agreement's original Effective Date or subsequent renewal date. A Plan Year may or may not be the same as a Calendar Year.

Timely Filing of Claims

Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. A claim that is not filed in a timely manner will be denied unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may, however, Appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner.

Freedom of Choice of Provider

Nothing contained in this Summary Plan Description is designed to restrict You in selecting the Provider of Your choice for vision care or treatment.

Concerns About Claim Denial or Other Action

If You have a concern regarding a claim denial or other action under these VSP benefits and wish to have it reviewed, You may Appeal. See the Appeal Process provision in this Summary Plan Description for a description of the process for Appeals.

Claims Determinations

Within 30 days of the Claims Administrator's receipt of a claim, You will be notified of the action taken on it. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When action cannot be taken on the claim due to circumstances beyond the Claims Administrator's control, they will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when the Claims Administrator expects to act on the claim.
- When action cannot be taken on the claim due to lack of information, the Claims Administrator will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

If the Claims Administrator seeks additional information from You, You will be allowed at least 45 days to provide the additional information. If the Claims Administrator does not receive the requested information to process the claim within the time allowed, the claim will be denied.

NONASSIGNMENT AND NONASSIGNMENT OF VOTING RIGHTS

Only You are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else and You (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity. Any attempted assignment, transfer or delegation of benefits will be considered null and void and will not be binding on the Plan. You may not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

A Plan holder entitled to vote on any matter of corporation business may not assign or in any way delegate such voting right to any other person or entity, other than by a validly executed written proxy filed with the Claims Administrator in compliance with the Claims Administrator's bylaws.

CLAIMS RECOVERY

If a benefit to which You were not entitled is paid under the Plan, or if a person who is not eligible for benefits at all is paid under the Plan, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a Provider of services. The Plan's right to recovery for an erroneous payment made on the Participant's or any of his or her Beneficiary's behalf includes the right to deduct the mistakenly paid amount from future benefits that would provide the Participant or any of his or her Beneficiaries under this Plan.

The Claims Administrator regularly works to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). All recovered amounts will be credited to the Plan.

For the recovery of overpayments related to the coordination of Primary and Secondary Health Plan benefits, refer to the Coordination of Benefits provision in this Claims Administration Section.

This Claims Recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the other-party liability provision in the Claims Administration Section for additional information.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND VISION RECORDS

It is important to understand that Your personal health information may be requested or disclosed by the Claims Administrator. This information will be used for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law.

The information requested or disclosed may be related to treatment or services received from:

- an insurance carrier or group health plan;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies;
- a clinic, hospital, long-term care or other medical facility; or
- a Physician, dentist, pharmacist or other physical or behavioral health care Practitioner.

Health information requested or disclosed by the Claims Administrator may include, but is not limited to:

- billing statements;
- claim records;
- correspondence;
- dental records;
- diagnostic imaging reports;
- hospital records (including nursing records and progress notes);
- laboratory reports; and
- medical records.

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by visiting the Claims Administrator's Web site or contacting Customer Service.

You have the right to request, inspect and amend any records that the Claims Administrator has that contain Your personal health information. Please contact the Claims Administrator's Customer Service department to make this request.

NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services and genetic testing. A specific authorization will be obtained from You in order for the Claims Administrator to receive information related to these health conditions.

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a vision care Provider. Neither the Plan nor the Claims Administrator is responsible for the quality of vision care You receive, since all those who provide care do so as independent contractors. Since neither the Plan nor the Claims Administrator provides any vision care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving vision services or supplies provided by professionals who are neither employees nor agents of the Plan or the Claims Administrator.

In addition, the Claims Administrator will not be liable to any person or entity for the inability or failure to procure or provide the benefits in the Plan by reason of epidemic, disaster or other cause or condition beyond the Claims Administrator's control.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Claimants who incur claims and are or have been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of Your estate, Your decedents, minors, and incompetent or disabled persons. No adult Claimant hereunder, may assign any rights that it may have to recover expenses from any tortfeasor or other person or entity to any minor child or children of said adult Claimant without the prior express written consent of the Plan.

The Plan's Right of Subrogation or reimbursement, as set forth below, extend to all insurance coverage available to You due to an Injury, Illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

This Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage, excess coverage or similar contract or insurance.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The "Right of Subrogation" means the Plan is entitled to pursue any claims that You may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of Your rights of recovery with respect to any claim or potential claim against any party, due to an Injury, Illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

If You receive any payment as a result of an Injury, Illness or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that Injury, Illness or condition, up to and including the full amount of Your recovery. Benefit payments made under the Plan are conditioned upon Your agreement to reimburse the Plan in full from any recovery You receive for Your Injury, Illness or condition.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to You or made on Your behalf to any Provider) You agree that if You receive any payment as a result of an Injury, Illness or condition, You will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of Your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the Illness, Injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any Illness, Injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, You, Your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, You agree to assign to the Plan any benefits or claims or rights of recovery You have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have, whether or not You choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, You acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before You receive any recovery for Your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make You whole or to compensate You in part or in whole for the damages sustained. The Plan is not required to participate in or pay Your court costs or attorney fees to any attorney You hire to pursue Your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire Subrogation and Right of Recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than expenses provided by the Plan. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to Your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is Your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Injury, Illness or condition. You and Your agents agree to provide the Plan or its representatives notice of any recovery You or Your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt of recovery funds. Further, You and Your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery You receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Your health benefits or the institution of court proceedings against You.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the Injury, Illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Workers' Compensation

If the entity providing workers' compensation coverage denies Your claim and You have filed an appeal, benefits may be advanced for Covered Services if You agree to hold any recovery obtained in a segregated account for the Plan.

Future Medical Expenses

Benefits for otherwise Covered Services may be excluded when You have received a recovery from another source relating to an Illness or Injury for which benefits would normally be provided. However, the amount of any Covered Services excluded under this provision will not exceed the amount of Your recovery.

Interpretation

In the event that any claim is made that any part of this Subrogation and Right of Recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator shall have the sole authority to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, You agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, You hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of Your present or future domicile. By accepting such benefits, You also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

COORDINATION OF BENEFITS

If You are covered under any other individual or group medical contract or policy (referred to as "Other Plan" and defined below), the benefits in this Plan and those of the Other Plan will be coordinated in accordance with the provisions of this section. NOTE: This Section refers to a broad range of benefits, even though this plan is a Vision Only plan.

Benefits Subject to this Provision

All of the benefits provided in this Summary Plan Description are subject to this Coordination of Benefits provision.

Definitions

In addition to the definitions in the Definitions Section, the following are definitions that apply to this Coordination of Benefits Section:

Allowable Expense means, with regard to services that are covered in full or part by this Plan or any Other Plan(s) covering You, the amount on which that Plan would base its benefit payment for a service, including Coinsurance or Copayments and without reduction for any applicable Deductible, except that the following are examples of expenses that are not an Allowable Expense:

- An expense or portion of an expense not covered by any of Your involved Plans.
- Any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless one of Your involved Plans provides coverage for private Hospital rooms.
- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that Plan's provisions regarding second surgical opinion or preauthorization.
- If You are covered by two or more Plans that: 1) compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit; or 2) that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
- If You are covered by a Plan that calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, that negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

When a Plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

Birthday, for purposes of these Coordination of Benefits provisions, means only the day and month of birth, regardless of the year.

Custodial Parent means the legal Custodial Parent or the physical Custodial Parent as awarded by a court decree. In the absence of a court decree, Custodial Parent means the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

Group-Type Coverage is a coverage that is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including blanket coverage. Group-Type Coverage does not include an individually underwritten and issued guaranteed renewable coverage, even if the coverage is purchased through payroll deduction at a premium savings to You (since You would have the right to maintain or renew the coverage independently of continued employment with the employer).

Other Plan means any of the following with which this coverage coordinates benefits:

- Individual and group accident and health insurance and subscriber contracts.
- Uninsured arrangements of group or Group-Type Coverage.
- Group-Type Coverage.
- Coverage through closed panel Plans (a Plan that provides coverage primarily in the form of services through a panel of providers that have contracted with or are employed by a Plan and that excludes

benefits for services provided by other providers, except in the cases of emergency or referral by a panel member).
- Medical care components of long-term care contracts, such as skilled nursing care.
- Medicare and other governmental coverages, as permitted by law.

Other Plan does not include:

- Hospital indemnity coverage benefits or other fixed indemnity coverage.
- Accident only coverage.
- Specified disease or specified accident coverage.
- Limited benefit health coverage.
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.
- Benefits provided in long-term care insurance policies for non-medical services (for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and Custodial Care) or for coverages that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
- Medicare supplement coverage.
- A state plan under Medicaid, or a governmental plan that, by law, provides benefits that are in excess to those of private insurance or other nongovernmental coverage.

Primary Plan means the Plan that must determine its benefits for Your health care before the benefits of another Plan and without taking the existence of that Other Plan into consideration. (This is also referred to as the Plan being "primary" to another Plan.) There may be more than one Primary Plan. A Plan is a Primary Plan with regard to another Plan in any of the following circumstances:

- The Plan has no order of benefit determination provision or its order of benefit determination provision differs from the order of benefit determination provision included herein; or
- Both Plans use the order of benefit determination provision included herein and under that provision the Plan determines its benefits first.

Secondary Plan means a Plan that is not a Primary Plan.

Year, for purposes of this Coordination of Benefits provision, means Calendar Year (January 1 through December 31).

Order of Benefit Determination

The order of benefit determination is identified by using the first of the following rules that applies:

Non-dependent or dependent coverage: A Plan that covers You other than as a dependent, for example as an employee, member, policyholder retiree, or subscriber, will be primary to a Plan under which You are covered as a dependent.

Child covered under more than one Plan: Plans that cover You as a child shall determine the order of benefits as follows:

- When Your parents are married or living together (whether or not they have ever been married), the Plan of the parent whose Birthday falls earlier in the Year is the Primary Plan. If both parents have the same Birthday, the Plan that has covered a parent longer is the Primary Plan.
- When Your parents are divorced or separated or are not living together (if they have never been married) and a court decree states that one of Your parents is responsible for Your health care expenses or health care coverage, the Plan of that parent is primary to the Plan of Your other parent. If the parent with that responsibility has no health care coverage for Your health care expenses, but that parent's spouse does, the Plan of the spouse shall be primary to the Plan of Your other parent.
- If a court decree states that both parents are responsible for Your health care expenses or health care coverage, or if a court decree states that the parents have joint custody of You, without specifying that one of the parents is responsible for Your health care expenses or health care

coverage, the provisions of the first bullet above (based on parental Birthdays) shall determine the order of benefits.

- If there is no court decree allocating responsibility for Your health care expenses or health care coverage, the order of benefits is as follows:

  - The Plan of Your custodial parent shall be primary to the Plan of Your custodial parent's spouse;
  - The Plan of Your custodial parent's spouse shall be primary to the Plan of Your noncustodial parent; and
  - The Plan of Your noncustodial parent shall be primary to the Plan of Your noncustodial parent's spouse.

If You are covered under more than one Plan and one or more of the Plans provides You coverage through individuals who are not Your parents (for example, a guardian or step-parent), the order of benefits shall be determined, as applicable using the provisions under the first or second bullets above, as if those individuals were Your parents.

Active, retired, or laid-off employees: A Plan that covers You as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee, is primary to a Plan under which You are covered as a laid off or retired employee. If the Other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

COBRA or state continuation coverage: A Plan that covers You as an employee, member, subscriber or retiree or as a dependent of an employee, member, subscriber or retiree, is primary to a Plan under which You are covered pursuant to COBRA or a right of continuation pursuant to state or other federal law. If the Other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

Longer/shorter length of coverage: When none of the paragraphs above establishes an order of benefit determination, the benefits of the Plan that has covered You for the longer period of time will be determined before the benefits of the Plan that has covered You for the shorter period of time. To determine the length of time You have been covered under a Plan, two successive Plans will be treated as one if You were eligible under the second Plan within 24 hours after coverage under the first Plan ended. The start of a new Plan does not include:

- a change in the amount or scope of a Plan's benefits;
- a change in the entity that pays, provides or administers the Plan's benefits; or
- a change from one type of Plan to another (such as from a single-employer Plan to a multiple employer Plan).

Your length of time covered under a Plan is measured from Your first date of coverage under that Plan. If that date is not readily available for a group Plan, the date You first became a member of the group will be used as the date from which to determine the length of time coverage under the present Plan has been in force.

If an order of benefit determination is not identified by the preceding rules, the Plans shall share equally in the Allowable Expenses. Each of the Plans under which You are covered, and each of the benefits within the Plan, will be considered separately in administering this Coordination of Benefits provision.

Primary Health Plan Benefits

When, in accordance with the order of benefit determination, this coverage is the Primary Plan, benefits of this Plan will be paid as if no Other Plan exists. Despite the provisions of timely filing of claims, where this Plan is the Primary Plan, benefits will not be denied under this Plan on the ground that a claim was not timely submitted if the claim was timely submitted to one or more Secondary Plans and was submitted to the Claims Administrator within 36 months of the date of service.

Secondary Health Plan Benefits

If, in accordance with the order of benefit determination, one or more Other Plans are primary to this Plan, the benefits of this Plan will be calculated as follows:

The benefits that would have been paid under this Plan for a service if this Plan were the Primary Plan will be calculated. That calculated amount will be applied to any Allowable Expense under this Plan for that service that is unpaid by the Primary Plan. Regence will:

- reduce payment so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed 100 percent of the total Allowable Expense for that claim; and
- credit to this Plan's Deductible (if applicable), any amounts that would have been credited for the service if this Plan were the Primary Plan.

Nothing contained in this Coordination of Benefits provision requires this Plan to pay for all or part of any service that is not covered under this Plan. Further, in no event will this Coordination of Benefits provision operate to increase this Plan's payment over what would have been paid in the absence of this Coordination of Benefits provision.

Right to Receive and Release Needed Information

Certain facts are needed to apply Coordination of Benefits provisions. The Claims Administrator has the right to decide which facts they need. The Claims Administrator may get needed facts from, or give them to, any other organization or person as permitted by law, and need not tell or get the consent of any person to do this. You will promptly furnish to the Claims Administrator any information necessary or appropriate to administer this Coordination of Benefits provision. Receipt of such information by the Claims Administrator will be a condition precedent to this Plan's obligation to provide benefits.

Right of Recovery

If benefits under this Plan to or on behalf of You in excess of the amount that would have been payable in this Plan by reason of Your coverage under any Other Plan(s), this Plan will be entitled to the excess as follows:

- From You, if payment was made to You. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentations. This Plan will be entitled to recover the amount of such excess by the reversal of payment from You and You agree to reimburse this Plan on demand for any and all such amounts. You also agree to pay this Plan interest at 18 percent per annum until such debt is paid in full, which will begin accruing the date the demand for reimbursement is made. If a third-party collection agency or attorney is used to collect the overpayment, You agree to pay collection fees incurred, including, but not limited to, any court costs and attorney fees. If You do not pay, future benefits under this Plan may be withheld to offset the amount owing to it. The Claims Administrator is responsible for making proper adjustments between insurers and Providers.
- From Providers, if payment was made to them. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentation(s). The Claims Administrator is responsible for making proper adjustments between insurers and Providers.
- From the Other Plan or an insurer.
- From other organizations.

A Secondary Plan that provides benefits in the form of services may recover the reasonable cash value of the services from the Primary Plan to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by it.

Appeal Process

If You or Your representative (any representative authorized by You) has a concern regarding a claim denial or other action under the Plan and wishes to have it reviewed, You may appeal. For the purposes of this provision, an "appeal" means a written or verbal complaint, concern, grievance or disagreement regarding access to care, quality of care, treatment, service, communication or claim.

Appeals

Appeals can be initiated through either written or verbal request. The appeal process will be handled through VSP. A written request can be made by completing the form available at **www.vsp.com** or by sending via mail to VSP at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento CA 95899-7100. Verbal requests can be made by calling VSP's Customer Service department at: 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance).

Time Frames

Written acknowledgement is sent to the person submitting the appeal within five calendar days of receipt. The acknowledgement will advise the Claimant that the appeal has been received, the date of the receipt, and a telephone number to contact a VSP representative about the appeal. The Claimant's appeal is forwarded to the appropriate parties, as required.

VSP is responsible for resolving appeals within 30 calendar days of receipt unless otherwise required under federal law.

The time limitation for receipt of appeal is one year from the date of service or one year from the Claimant point of realization of the problem, or as otherwise required under federal law. The Claimant will be notified within one business day if the appeal exceeds the one year time limitation.

Information

If You have any questions about the appeal process outlined here, You may contact VSP's Customer Service department at: 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance).

Who Is Eligible, How to Enroll and When Coverage Begins

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible or during an annual enrollment period. It also describes when coverage under the Plan begins for You and/or Your eligible dependents. Of course, payment of any corresponding monthly costs is required for coverage to begin on the indicated dates.

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of Your first becoming eligible for coverage under the eligibility requirements in effect with the Plan Sponsor and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

If You and/or Your eligible dependents do not enroll for coverage under the Plan when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual enrollment period to enroll.

Employees

You become eligible to enroll in coverage on the date You have worked for the Plan Sponsor long enough to satisfy the required 90 day probationary period.

Dependents

Your Beneficiaries are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when the Claims Administrator has enrolled them in coverage under the Plan. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your domestic partner, provided that all of the following conditions are met:
    - You have completed, executed and submitted an affidavit of qualifying domestic partnership form with regard to Your domestic partner;
    - both You and Your domestic partner are age 18 or older;
    - You and Your domestic partner share a close, personal relationship and are responsible for each other's common welfare;
    - neither You nor Your domestic partner is legally married to anyone else or has had another domestic partner within the 30 days immediately before enrollment of Your domestic partner;
    - You and Your domestic partner share the same regular and permanent residence and intend to continue doing so indefinitely;
    - You and Your domestic partner share joint financial responsibility for Your basic living expenses, including food, shelter and medical expenses; and
    - You and Your domestic partner are not more closely related by blood than would bar marriage in Your state of residence.
- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:
    - Your (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
    - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
    - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and who is a Disabled Dependent due to a Physical Impairment or a Mental Impairment that began before his or her 26th birthday, if You complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's impairment, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:

- he or she is a Beneficiary immediately before his or her 26th birthday; or
- his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage since that birthday.

The Claims Administrator's affidavit of dependent eligibility form is available by visiting their Web site or by contacting Customer Service.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request (and, for a domestic partner, an affidavit of qualifying domestic partnership form) to the Claims Administrator. Request for enrollment of a new child by birth, adoption or placement for adoption must be made within 60 days of the date of birth, adoption or placement for adoption. Request for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates (which, for a new child by birth, adoption or placement for adoption, is the date of birth, adoption or placement for adoption, if enrolled within the specified 60 days).

NOTE: When the addition of a new child by birth, adoption or placement for adoption would not cause a change in Your payment under the Plan (as of the date of birth, adoption or placement for adoption), You will have 60 days as of the date the Claims Administrator first sends a denial of a claim for benefits for that new dependent to submit a signed group change request.

ANNUAL ENROLLMENT PERIOD

The annual enrollment period is the only time, other than initial eligibility or a special enrollment period, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form (and, in the case of a domestic partner, a completed affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

TRANSFER DURING ANNUAL ENROLLMENT PERIOD

The annual enrollment period is the period of time during which You and/or Your eligible dependents may transfer directly to the Plan described in this Summary Plan Description from one of the Plan Sponsor's other health benefit plans. You must file an enrollment form (and, in the case of a domestic partner, a completed affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished any information necessary and appropriate to determine the eligibility of a dependent. Such information must be received before enrolling a person as a dependent under the Plan.

DEFINITIONS SPECIFIC TO THE WHO IS ELIGIBLE, HOW TO ENROLL AND WHEN COVERAGE BEGINS SECTION

Disabled Dependent means a child who is and continues to be: 1) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable Physical or Mental Impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and 2) dependent on You for more than 50 percent of their support (food, shelter, clothing, medical and dental care, education and the like).

Mental Impairment means a mental or psychological disorder such as: 1) intellectual disability; 2) organic brain syndrome; 3) emotional or mental illness or 4) specific learning disabilities as determined by the Claims Administrator.

Physical Impairment means a physiological disorder, condition or disfigurement, or anatomical loss affecting one or more of the following body systems: 1) neurological; 2) musculoskeletal; 3) special sense organs; 4) respiratory organs; 5) speech organs; 6) cardiovascular; 7) reproductive; 8) digestive; 9) genito-urinary; 10) hemic and lymphatic; 11) skin or 12) endocrine.

When Coverage Ends

This section describes the situations when coverage will end for You and/or Your Beneficiaries. You must notify the Claims Administrator within 30 days of the date on which an enrolled Beneficiary is no longer eligible for coverage.

No person will have a right to receive any benefits after the Plan terminates. Termination of Your or Your Beneficiary's coverage under the Plan for any reason will completely end all obligations to provide You or Your Beneficiary benefits for Covered Services received after the date of termination. This applies whether or not You or Your Beneficiary is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while the Plan was in effect.

AGREEMENT TERMINATION

If the Agreement is terminated or not renewed, claims administration by Regence ends for You and Your Beneficiaries on the date the Agreement is terminated or not renewed (except, if agreed between the Plan Sponsor and Regence, Regence may administer certain claims for services that Claimants received before that termination or nonrenewal).

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, Your and Your Beneficiaries' coverage ends on the date on which Your eligibility ends. However, it may be possible for You and/or Your Beneficiaries to continue coverage under the Plan according to the continuation of coverage provisions in this Summary Plan Description.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Plan, Your coverage will end for You and all Beneficiaries on the date on which employment ends.

NONPAYMENT

If You fail to make required timely contributions to the cost of coverage under the Plan, Your coverage will end for You and all Beneficiaries.

FAMILY AND MEDICAL LEAVE

If Your employer grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA") the following rules will apply. The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the FMLA:

- You and Your Beneficiaries will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
  - in order to care for Your newly born child;
  - in order to care for Your spouse, child or parent, if such spouse, child or parent has a serious health condition;
  - the placement of a child with You for adoption or foster care; or
  - You suffer a serious physical or mental health condition.

During the FMLA leave, You must continue to make payments for coverage through the Plan Sponsor on time. The provisions described here will not be available if the Plan terminates.

If You and/or Your Beneficiaries elect not to remain enrolled during the FMLA leave, You (and/or Your Beneficiaries) will be eligible to be reenrolled under the Plan on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new enrollment form just as if You were a newly eligible employee. In this situation, if You reenroll within the required time, all of the terms and conditions of the Plan will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Beneficiaries) will receive credit for any waiting period served before the

FMLA leave and You will not have to re-serve any probationary period under the Plan, although You and/or Your Beneficiaries will receive no waiting period credits for the period of noncoverage.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purpose of COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Plan Sponsor must keep the Claims Administrator advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

LEAVE OF ABSENCE

If You are granted a non-FMLA temporary leave of absence by Your employer, You can continue coverage for up to three months. Payments must be made through the Plan Sponsor in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by Your employer at Your request during which You are still considered to be employed and are carried on the employment records of the Plan Sponsor. A leave can be granted for any reason acceptable to Your employer. If You are on leave for an FMLA-qualifying reason, You remain eligible under the Plan only for a period equivalent to FMLA leave and may not also continue coverage under a non-FMLA leave.

If You and/or Your Beneficiaries elect not to remain enrolled during the leave of absence, You (and/or Your Beneficiaries) may reenroll under the Plan only during the next annual enrollment period.

WHAT HAPPENS WHEN YOUR ENROLLED BENEFICIARIES ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the last day of the monthly period in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the continuation of coverage provisions in this Summary Plan Description.

Divorce or Annulment

Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the date a divorce or annulment is final.

If You Die

If You die, coverage for Your Beneficiaries ends on the date on which Your death occurs.

Termination of Domestic Partnership

If Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the date of termination of the domestic partnership. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. You may not file another affidavit of qualifying domestic partnership within 90 days after a request for termination of a domestic partnership has been received.

Loss of Dependent Status

- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the monthly period in which the child exceeds the dependent age limit.

- For an enrolled child who is no longer eligible due to disruption of placement before legal adoption and who is removed from placement, eligibility ends on the last day of the monthly period in which the child is removed from placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the monthly period in which the child is no longer a dependent.

OTHER CAUSES OF TERMINATION

Claimants terminated for any of the following reasons may be able to continue coverage under the Plan according to the continuation of coverage provisions in this Summary Plan Description.

Strike or Other Labor Dispute

Coverage ends on the date you are no longer actively at work due to a strike or other labor dispute.

Fraudulent Use of Benefits

If You or Your Enrolled Beneficiary engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under the Plan will terminate for that Claimant. The Claimant may reenroll 12 months after the date of discontinuance if the Plan Sponsor's coverage is in effect at the time the Claimant applies to reenroll.

Fraud or Misrepresentation in Application

Coverage under the Plan is based upon all information furnished to the Claims Administrator, for the benefit of the Plan by You or on behalf of You and Your Beneficiaries. In the event of any intentional misrepresentation of material fact or fraud, the Plan will have the following rights in accordance with Utah Code 31A-22-721 (or any successor thereto):

- With regard to a Claimant's health status, a retrospective adjustment to the cost of coverage under the Plan may be made as would have been appropriate if true, accurate or complete information had been provided at the time of enrollment.
- With regard to a Claimant (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Plan), coverage will be retroactively adjusted to the terms that would have existed if true, accurate or complete information had been received.

COBRA Continuation of Coverage

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups.

If the Plan is subject to COBRA, COBRA continuation is available to Your Beneficiaries if they lose eligibility because:

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce or the marriage is annulled;
- You and Your domestic partner terminate the domestic partnership;
- You become entitled to Medicare benefits; or
- Your Beneficiary loses eligibility as a child under this coverage.

COBRA also is available to You if You lose eligibility because Your employment terminates (other than for gross misconduct) or Your hours of work are reduced. (A special COBRA continuation also applies to You and Your Beneficiaries under certain conditions if You are retired and Your employer files for bankruptcy.)

There are some circumstances involving disability or the occurrence of a second one of these events that can result in extension of the limited period of continuation following a termination of employment or reduction in working hours. COBRA also can terminate earlier than the maximum periods.

General Rules

Generally, You or Your Beneficiaries are responsible for payment of the full cost for COBRA continuation, plus an administration fee, even if the Plan Sponsor contributes toward the cost of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Beneficiary's rights under COBRA, You or Your Beneficiaries must inform the Plan Sponsor in writing within 60 days of:

- Your divorce or annulment, termination of domestic partnership or a loss of eligibility of a child;
- Your initial loss of eligibility due to Your termination of employment or reduction in working hours and You experience another one of the events listed above; or
- a Social Security disability determination that You or Your Beneficiary was disabled for Social Security purposes at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that You or Your Beneficiary is no longer disabled for Social Security purposes, You or Your Beneficiary must provide the Plan Sponsor notice of that determination within 30 days of the date it is made.)

The Plan Sponsor also must meet certain notification, election and payment deadline requirements. It is therefore very important that You keep the Plan Sponsor informed of the current address of all Claimants who are or may become qualified beneficiaries.

If You or Your Beneficiaries do not elect COBRA continuation coverage, coverage under the Plan will end according to the terms of the Agreement and claims under the Plan for services provided on and after the date coverage ends will not be paid. Further, this may jeopardize Your or Your Beneficiaries' future eligibility for an individual plan.

Notice

The complete details on the COBRA Continuation provisions outlined here are available from the Plan Sponsor.

General Provisions

This section explains various general provisions regarding Your benefits under this coverage.

CHOICE OF FORUM

Any legal action arising out of the Plan benefit option described herein must be filed in a court in the state of Utah.

GOVERNING LAW AND DISCRETIONARY LANGUAGE

The Plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Utah without regard to its conflict of law rules. The Plan Administrator, the Plan Sponsor, delegates the Claims Administrator discretion for the purpose of paying benefits under this coverage only if it is determined that You are entitled to them and of interpreting the terms and conditions of the Plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations in federal court. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when You seek judicial review of a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the Plan. The Claims Administrator is not the Plan Administrator, but does provide claims administration under the Plan, and the court will determine the level of discretion that it will accord the Claims Administrator's determinations.

PLAN SPONSOR IS AGENT

The Plan Sponsor is Your agent for all purposes under the Plan and not the agent of Regence BlueCross BlueShield of Utah. You are entitled to health care benefits pursuant to the Plan. In the Agreement, the Plan Sponsor agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in this Summary Plan Description. You, through the enrollment form signed by the Participant, and as beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Summary Plan Description.

NO WAIVER

The failure or refusal of either party to demand strict performance of the Plan or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the Plan will be considered waived unless such waiver is reduced to writing and signed by one of the Plan Sponsor's authorized officers.

NOTICES

Any notice to Claimants or to the Plan Sponsor required in the Plan will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant or to the Plan Sponsor will be addressed to the Participant or to the Plan Sponsor at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address form (COA) for a Participant, it will update its records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Administrator or Plan Sponsor if it becomes aware that it doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be given by mail addressed to: Regence BlueCross BlueShield of Utah, P.O. Box 2998, Tacoma, WA 98401-2998; provided, however that any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Plan Sponsor on behalf of itself and its Claimants expressly acknowledges its understanding that the Agreement constitutes an agreement solely between the Plan Sponsor and Regence, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting Regence to use the Blue Cross and Blue Shield Service Marks in the state of Utah and that Regence is not contracting as the agent of the Association. The Plan Sponsor on behalf of itself and its Claimants further acknowledges and agrees that it has not entered into the Agreement based upon representations by any

person or entity other than Regence and that no person or entity other than Regence will be held accountable or liable to the Plan Sponsor or the Claimants for any of Regence's obligations to the Plan Sponsor or the Claimants created under the Agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence other than those obligations created under other provisions of the Agreement.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an enrollment form will be considered representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered in this Plan, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

- the person is eligible to be covered according to the eligibility provisions described in the Plan Document; and
- the person has enrolled in coverage and has been enrolled by the Claims Administrator.

The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You.

Definitions

The following are definitions of important terms used in this Summary Plan Description. Other terms are defined where they are first used.

Allowed Amount means:

- For VSP Doctors (see definition of "VSP Doctor" below), the amount that these Providers have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network Provider" below) the billed amount for listed services and supplies.

Charges in excess of the Allowed Amount are not considered reasonable charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, please contact the Claims Administrator.

Beneficiary means a Participant's eligible dependent who is listed on the Participant's completed enrollment form and who is enrolled under the Plan.

Benefit Authorization means VSP has approved benefits for You.

Calendar Year means the period from January 1 through December 31 of the same year; however, the first Calendar Year begins on the Claimant's Effective Date.

Claimant means a Participant or a Beneficiary.

Covered Service means a service, supply, treatment or accommodation that is listed in the Vision Benefits Section in this Summary Plan Description.

Effective Date means the date Your coverage under the Agreement begins after acceptance for enrollment under the Plan.

Experimental Nature means a procedure or lens that is not used universally or accepted by the vision care profession.

Family means a Participant and his or her Beneficiaries.

Frequency Period is the number of Calendar Years, usually one or two, that must pass before benefits renew.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: disease, Illness, Injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

Health Outcome means an outcome that affects health status as measured by the length or quality of a person's life. The Health Intervention's overall beneficial effects on health must outweigh the overall harmful effects on health.

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy.

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Investigational means a Health Intervention that the Claims Administrator has classified as Investigational. The Claims Administrator will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Investigational. A Health Intervention not meeting all of the following criteria is, in the Claims Administrator's judgment, Investigational:

- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Medically Necessary or Medical Necessity means health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an Illness or Injury or its symptoms in a manner that is:

- in accordance with generally accepted standards of medical practice in the United States;
- clinically appropriate in terms of type, frequency, extent, site, and duration;
- not primarily for the convenience of the patient, Physician, or other health care Provider; and
- covered under the Plan;

When a medical question-of-fact exists, Medical Necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and that is known to be effective. For Health Interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established Health Interventions, the effectiveness shall be based on first Scientific Evidence; then professional standards; and then expert opinion.

A HEALTH INTERVENTION MAY BE MEDICALLY INDICATED YET NOT BE A COVERED SERVICE UNDER THE PLAN OR OTHERWISE MEET THIS DEFINITION OF MEDICAL NECESSITY.

Out-of-Network Provider means any optometrist, optician, ophthalmologist or other licensed and qualified vision care Provider who has not contracted with VSP to provide vision care services and/or vision care materials.

Participant means an employee of the Plan Sponsor who is eligible under the terms described in this Summary Plan Description, has completed an enrollment form and is enrolled under this coverage.

Physician means an individual who is duly licensed to practice medicine and surgery in all of its branches or to practice as an osteopathic Physician and surgeon.

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians (for example, an optometrist).

Provider means a Physician, Practitioner or other individual or organization which is duly licensed to provide the services covered in this Summary Plan Description.

Regence refers to Regence BlueCross BlueShield of Utah.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Summary Plan Description (SPD) is a summary of the benefits provided by the Group Health Plan (GHP). A GHP with different benefit plan options may describe them in one SPD or in separate SPDs for each alternative benefit plan option.

VSP Doctor means an optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials to Claimants in accordance with the provisions of this coverage.

Summary Plan Description

The Plan is an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA). For further information regarding ERISA, contact the Plan Sponsor. Note that the terms "You" and "Your" in this Summary Plan Description Section by and large refer to the Participant.

PLAN NAME

Swire Pacific Holdings Inc., dba Swire Coca-Cola USA
12634 South 265 West
Draper, UT 84020
(801) 816-5300

EMPLOYER IDENTIFICATION NUMBER ASSIGNED FOR THIS PLAN BY THE IRS

87-0424812

PLAN NUMBER

60021265

TYPE OF PLAN

Welfare Benefit Plan: vision benefits

TYPE OF ADMINISTRATION

The processing of claims for benefits under the terms of the Plan are provided through a company contracted by the Plan Sponsor which hereinafter is referred to as the Claims Administrator.

NAME, ADDRESS AND PHONE NUMBER OF PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS

Swire Pacific Holdings Inc., dba Swire Coca-Cola USA
12634 South 265 West
Draper, UT 84020
(801) 816-5300

Legal process may also be served upon the Plan Sponsor's address above.

SOURCES OF CONTRIBUTIONS TO THE PLAN

Contributions for plan expenses are obtained from Plan Sponsor and Participants.

FUNDING MEDIUM

Plan Sponsor will maintain an account for the receipt of money and property to fund the Plan, for the management and investment of such funds, and for the payment of Plan benefits and expenses from such funds.

All funds and earnings received by the Plan Sponsor will be applied toward payment of Plan benefits and reasonable expenses of administration of the Plan except to the extent otherwise provided by the Plan documents. The Plan Sponsor may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan.

Any fiduciary, employee, agent representative or other person performing services to or for the Plan shall be entitled to reasonable compensation for services rendered and for the reimbursement of expenses properly and actually incurred, unless such person already receives full-time pay from Plan Sponsor.

Enrollees shall look only to the Plan Sponsor's funds for payment of Plan benefits and expenses.

PLAN FISCAL YEAR ENDS ON

December 31

PLAN TERMINATION PROVISIONS

The Plan Sponsor expects and intends to continue the Plan indefinitely, but reserves its right to end the Plan at any time in its sole discretion. The Plan Sponsor also reserves the right to amend the Plan at any time in its sole discretion.

The Plan Sponsor's decision to end or amend the Plan may be due to changes in federal or state laws governing welfare benefits, the requirements of the IRS or ERISA, or for any other reason. A Plan change may transfer assets and liabilities to another plan or split this plan into two or more parts. If the Plan Sponsor does change or end the Plan, it may decide to set up a different plan providing similar or identical benefits.

If the Plan is terminated, plan participants and beneficiaries will not have any further rights. The amount and form of any final benefit will depend on any contract provisions affecting the Plan, and the Plan Sponsor's decisions.

NOTICE OF ERISA RIGHTS

As a participant under the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Receive a summary of the Plan's annual financial report. The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

Continue Employer Health Plan Coverage

Continue health care coverage for Yourself, spouse or children if there is a loss of coverage under the Plan as a result of a qualifying event under COBRA. You or Your Beneficiaries may have to pay for such coverage. Review this Plan Document and the documents governing the Plan for a description of the rules governing Your COBRA continuation coverage rights.

You should be provided a certificate of creditable coverage, free of charge, from Your group health plan when You lose coverage under the Plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

No one, including the Plan Sponsor or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a health and welfare benefit under the Plan or exercising Your rights under ERISA. If Your claim for a health and welfare benefit is denied in whole or in part, You must receive a written explanation of the reasons for the denial. You have the right to have the Plan Sponsor review and reconsider Your claim. Under ERISA, there are steps You can take to enforce these rights. For instance, if You request materials from the Plan and You do not receive them within 30 days, You may file suit in the Federal court. In such case, the court may require the Plan Administrator to

provide the material and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

Procedures For Filing Claims

If You have a claim for benefits (for Yourself or for one of Your Beneficiaries) which is denied or ignored in whole or in part, You have the right to a hearing before the Plan Sponsor at which You may present Your position and any supporting evidence. You also have the right to be represented by an attorney or any other representative of Your choice. Further, if You are dissatisfied with the Plan Sponsor's determination, You may pursue an action pursuant to 29 USC§1132(a).

For detailed information on how to submit a claim for benefits or how to file an appeal on a processed claim, refer to the Submission of Claims and Reimbursement and Appeals provisions in this Summary Plan Description.

In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that the plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the US Department of Labor, or You may file suit in Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance With Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA You should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue NW, Washington DC 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

For more information call the Claims Administrator at 1 (866) 240-9580 or You can write to P.O. Box 2998, Tacoma, WA 98401-2998

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